

Publicly Funded Mental Health and School Coordination Resource Manual



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Introduction

In the spring of 2007, the Office of Superintendent of Public Instruction (OSPI), in partnership with Washington's Mental Health Transformation Grant, contracted with the Area Health Education Center at Washington State University (WSU) Spokane in order to promote the intent of RCW 71.36.040 (3). Specifically, this work was to involve the creation and delivery of statewide train-the-trainers sessions to enhance coordination of mental health services between publicly funded education and publicly funded community mental health systems. An additional purpose of this work was to begin to develop Response to Intervention (RTI) strategies and practices specific to the emotional and behavioral well being of students. These trainings will be scheduled to occur within the boundaries of each of the nine Educational Service Districts (ESDs) in Washington State (Exhibit 3).

The contract required the establishment of a work group comprised of educators, Regional Support Network (RSN), community mental health service delivery staff, stakeholders, and parents. Work group notes are found in Exhibit 1. The work group was tasked to modify and rework two documents developed in 2003 which: (1) identify examples of coordination between the K–12 and mental health systems in Washington State, and (2) identify criteria for assessing and targeting areas of strength and promotion of promising practices. These documents were to become the basis for the train-the-trainers curriculum. Further, the Area Health Education Center was to conduct a review of the literature of accepted best practices in mental health services, and review information available regarding RTI principles specifically addressing mental health and student performance.

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We are also grateful to those who took time from busy schedules to be interviewed and share their expertise.

Executive Summary

The planning and development work for this project was completed May through September 2007. A statewide advisory committee was identified, formed, and met twice during that period (Exhibit 1). The advisory committee's function was to assist in framing the tasks and advise the contractor about the best methods and general sources to use in development of materials and training. The advisory committee was comprised of parents who understand and have worked with both the publicly funded mental health and the K–12 systems, and included representatives from both Public Mental Health and K–12 who had significant supervisory and administrative experience working with children and families within these systems. Washington State University and OSPI balanced membership to ensure representation of urban and rural perspectives.

This publicly funded Mental Health and School Coordination Resource Manual contains information gathered from a statewide survey that included representatives from the publicly funded mental health system, K–12, and parents. Information was received from a total of 124 individuals; four were parents, four were Regional Support Network (RSN) administrative staff, 13 were supervisory or administrative personnel from publicly funded local mental health provider agencies, and 103 were primarily administrative personnel from the K–12 system representing 77 school districts. We used a mix of open-ended and semi-structured interviews to learn, from their perspective, the state of publicly funded mental health services in schools in Washington. Interviews were completed in person, through phone, and email exchanges. Participant information was analyzed for principal themes regarding conditions for successful practice, examples of successful programs, and recommendations for future development.

If we are to be true to what parents and professionals have told us, one major finding defines where we are and how we need to move forward to create and expand collaborative responses to the mental health needs of children in schools. Existing solutions to mental health and school collaborations are uniquely local. There is no state level “cross-system” response to the mental health needs of school age children. Financing, eligibility standards, and the scope of problems each system is mandated to address, limit the points of mutually supportive effort on behalf of children with mental illnesses.

A review of literature addressing mental health and schools was completed. In that, we identified materials related to several aspects of the relationship between the two systems. Those included methods of financing, evidence-based practices in the delivery of services, and informational resources to use to guide the adaptation of RTI techniques. Each of these areas are essential to creating appropriate responses to children who experience, or are on a trajectory to experience, mental illnesses which interfere with a child's capacity to learn and function successfully in a K–12 setting.

Schools are obligated to respond to a broad range of behavioral and emotional needs that compromise students' and schools' success. Publicly funded mental health services are constrained to address the neediest children, as defined by income and severity of illness. Both systems are further challenged by a level of need that exceeds their available resources. Despite these systemic limitations, local communities often find a way to address some needs collaboratively. Examples and common themes are addressed in the body of this report. From this collective experience, several recommendations and lessons for training follow:

1. There is a strong foundation of evidence-based programs to build from in mental health in schools collaborative work. The issues are resources and training, not an absence of effective practice models.
2. The nature of collaboration between schools and mental health providers differs as the severity of children's needs increases. There are guidelines aligned to RTI principles that help guide when, how, and to what end collaborative practice can be developed.
3. School and mental health providers often do not understand each other well and this leads to myths and misperceptions in collaborative work. Building the level of mutual understanding about mission, structure, distinct vocabulary, and capacity is a critical foundation for effective collaboration.
4. Presently, the common themes across promising local programs depend on relationship and creation of the flexible funds that allow both schools and mental health providers to move outside of standard practices. The resulting programs only meet a small part of the need but offer the lessons for expanding services. These local programs are also only as stable as their funding sources.
5. The state's commitment to improving collaborative mental health in schools will require investment and public policy development. Local institutions can develop collaborative responses but need the financial capacity and flexibility to do so successfully.

The first four points above describe the principal tools for local collaborative program development. The last point defines the policy challenge to state leadership to address mental health as a principal barrier to the learning success of children in Washington State.

I. What is the Publicly Funded Mental Health System?

Washington State University and OSPI found a major impediment to cooperation or collaboration between the public mental health and K–12 systems was a lack of understanding about mandates, funding requirements, and structure as these pertain to the public mental health system.

Structure and Benefits

The statutory authority for the provision of health care for disabled, elderly, and low-income populations in the United States is Title XIX (Chapter 19) of the Social Security Act. Title XIX outlines two major programs, Medicare and Medicaid. Medicaid is the program most often referred to in discussions about health care coverage for low-income families and children. A portion of those benefits are targeted to the provision of mental health care to individuals with diagnosable mental illnesses.

Unlike Medicare, Medicaid is a state administered program. The scope of benefits are defined first in federal Medicaid administrative rules, and then made available to states. An agreement is based, generally speaking, on a fifty-fifty financial match arrangement. In this arrangement, states are required to create their own rule structures which define benefit limits and criteria for access, and submit them for approval to the federal Department of Health and Human Services (DHHS). Within Washington State, the responsibility for defining and approving overall health care limits and access lies within the Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA). Mental health benefits are included in this planning process and are the responsibility of the Mental Health Division (MHD), a sub-entity of HRSA.

The organizational structure for the delivery of publicly funded mental health services in Washington is somewhat similar to that which exists within the much larger K–12 system. Under contract with MHD, Regional Support Networks (RSNs) provide the regional infrastructure for administration, funding, and quality assurance services. Within each RSN is an array of community mental health agencies (nonprofit agencies) which subcontracts with RSNs to provide community-based, outpatient mental health services.

Adults and children become eligible for enrollment in Medicaid services based on income as indexed against the Federal Poverty Level (FPL) (Exhibit 4). Publicly funded health care benefits, including mental health, are available to adults who are at or below 100 percent of FPL. Children are eligible for Medicaid funded services up to 200 percent of the FPL. With the advent of the State Children's Health Insurance Program (SCHIP), children will be eligible for all benefits identified in the state Medicaid plan up to 250 percent of FPL.

While there is some variation across communities and agencies, most communities rely on Title XIX funded services to support local mental health services provided through the RSN system (Exhibit 2). Limited private insurance access and constrained or nonexistent use of local taxes to support social services has assured reliance on the Title XIX services as the dominant mental health resource for low-income families in most all Washington communities. The consequence of this reliance on the Title XIX systems is that rules governing these services define much of communities' mental health capacity.

(It is noted that in 2007 the Legislature passed, and the Governor signed, the Health Care Services for Children Act. This new policy is to be implemented progressively through 2009 and intends to expand service eligibility for children up to 300 percent of FPL with modest family co-pays. Because this legislation is new, its eventual impact is beyond scope of this report).

Access to Care Standards

Interviews and surveys completed for this report show that one of the least understood issues in the entire discussion about Title XIX mental health services for children is the state's Access to Care Standards. The Access to Care Standards are perceived as a principal constraint on the ability of local mental health providers to work collaboratively with school partners to respond to the full range of behavioral and emotional problems in children.

Within the framework of Medicaid statute and administrative regulations, each state is obliged to identify how they will participate by proposing rules that govern benefit allowances for each enrollee, identify the range of covered services and treatment modalities, and define the level of medical necessity that must exist in order for an individual to receive service, or "access to care." While virtually all children have access to emergency or crisis response services, only those children who are enrolled in the state's RSN system and meet medical necessity and Access to Care Standards have access to longer-term, publicly-funded, out-patient treatment services. The determination of eligibility for access to those services is based on the presence of a diagnosed mental illness which is defined in terms of its severity and persistence (Exhibit 5). The delivery of services within the publicly funded system is specifically organized around criteria which include no provision for prevention or early intervention services.

Given this framework for service eligibility, the advisory committee identified five groups of children who may experience a range of diagnosable mental illnesses and gain access to Title XIX funded treatment services.

1. A child is eligible for or enrolled in Medicaid or SCHIP and due to the nature and severity of diagnosed illness meets medical necessity which is defined by the Access to Care Standards. This child may receive the full range of publicly funded mental health services including emergency, crisis, assessment, and ongoing service.

2. A child is eligible for or enrolled in Medicaid or SCHIP and the mental health or behavioral concern is insufficient to meet Access to Care Standards. This child may receive crisis and emergency services.
3. A child is ineligible for Medicaid and has no other resources. This child may receive crisis and emergency services.
4. A child's family may have private health insurance but may have exhausted benefits or is unable to consistently manage the expense of co-pays or premiums. This child may receive crisis and emergency services.
5. A child's family has the financial resources available to purchase a full, unlimited range of mental health services. This child may also receive crisis and emergency services within the RSN system.

The result for schools and community mental health partners is that access to services for emotional and behavioral problems in children is defined by eligibility and access standards that define not one population but a continuum of populations. These eligibility and Access to Care Standards, in turn, define much of the flexibility mental health providers have in responding to need.

II. What is Mental Health in the Context of the Relationship Between the Publicly Funded Mental Health System and the K–12 System?

The American Heritage Dictionary defines mental health as “A state of emotional and psychological well being in which an individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life.”

While we talk in terms of the publicly funded RSN system, currently children and youth cannot access publicly funded mental health services unless they have a serious emotional disturbance that meets the criteria for medical necessity. The Access to Care Standards are used to define medical necessity for the purpose of outpatient mental health services under Washington’s Medicaid (Title XIX) program. When the Access to Care Standards are met, medical necessity is supported. This poorly understood reality has been the basis for frustration of practitioners in the mental health and schools systems.

Groups of individuals in every corner of the state have worked diligently to create collaborative programs to serve the needs of children who are clearly experiencing a range of bio-psycho-social problems that interfere with normal functioning. In many of these instances, educators and mental health professionals work around the same table to develop capacity to intervene early and to make services available to children and families without regard for income. However, the role of local public mental health agencies in these discussions is frequently constrained by reliance on Title XIX funding for their programs with its associated limits on service access, and the focus on crisis response, serious emotional disturbance, and severe mental illness.

Conventional wisdom suggests that a robust partnership between the public mental health system and K–12 is a logical and necessary step toward creating a system of care that responds to a range of emotional and behavioral problems in children. Certainly, for children who are income eligible and may be moving toward Special Education as a result of “behavioral disturbances,” or other relevant K–12 criteria, there is often a clear connection to be made. We saw evidence of that connection being made very frequently.

For children who may have a diagnosable mental illness but are not yet demonstrating sufficient evidence of serious emotional disturbance, the connections between the two systems are more difficult and often the source of frustration for all participants.

Compounding this problem is that K–12 professionals and mental health professionals enter these discussions with perspectives shaped by separate institutional priorities. Mental health professionals are oriented to determine the presence of medical necessity through assessment and diagnosis based on the criteria and treatment protocols found in the American Psychiatric Association's

Diagnostics and Statistics Manual IV (DSM IV). The education system's approach to assessment and response is organized by the Individuals with Disabilities Education Act (IDEA). The DSM IV's focus is psychopathology defined around abnormal behavior and the resulting functional impairment. IDEA's focus includes behavior disorders and academic deficits.

While professionals in both systems are concerned about levels of functional impairment, they measure it differently and have different languages to describe it. Diagnostic categories and combinations of categories are identified in the DSM IV and are descriptive of multiple levels of impairment to daily functioning. K–12 uses a variety of testing and assessment methods, and in Special Education can apply one or more of 14 different diagnostic categories, each with its own level of complexity. While both systems express common concern about the bio-psycho-social factors which impede a child's capacity to function in daily life, each system approaches the issue from different perspectives. Mental health professionals are trained to focus on broad areas of functioning including success in school, and K–12 professionals are expected to focus on those specific problems which interfere with successful adjustment and responsiveness to the learning environment.

In education, the national public policy discussion increasingly identifies the mental health needs of students as principal barriers to schools achieving expectations for student learning, the literature related to this issue is growing rapidly. While the role of schools in addressing the problem is far from resolved, there is increasing consensus that focusing on the social-emotional-behavior needs is essential to schools' ability to have students meet academic standards (Kutash et al., 2006). There is also growing consensus among system administrators and academics that the infrastructure for addressing these needs is fragmented (Adelman et al., 2005). When children experience chronic ruptures in their family, isolation from community life, and disruptions in their sense of self, they rarely enter classrooms prepared to benefit. Because the public mental health system is obliged to limit its involvement to those children with serious emotional disturbances, the K–12 system is being left to discover how to create responses to increasing numbers of children without assistance from agencies outside its own system.

What are the Prevalence Rates for Mental Illness in Children?

The most recent and widely regarded comprehensive estimates for the rates of mental illness in children are included in the 1999 *Surgeon General's Report on Children's Mental Health*. That report was cited as an authoritative source for the 2003, "President's New Freedom Commission on Mental Health" and is widely referenced in the mental health and education literature.

The Surgeon General's Report states that 21 percent of children experience a diagnosable mental illness annually. That is, more than one in five children experience a DSM IV diagnosable illness each year. R.M. Friedman and his colleagues (1996) stated that 9 percent to 15 percent of children experience a

condition that causes substantial functional impairment and that 5 percent to 9 percent of children experience severe emotional disturbances that result in extreme functional impairment. Friedman et al., also report that communities with comparatively high levels of poverty should expect to encounter a child population experiencing these problems at the higher end of each percentile range.

Despite the significant level of need in the population, only a minority of children receive services. According to the Surgeon General's Report, "about 75 to 80 percent (of children with a serious emotional disturbance) fail to receive specialty services, and (according to family members) the majority of these children fail to receive any services at all." Kutash et al., (2006) also cite evidence that the vast majority of children receive no mental health services and among those that do receive services, the majority received them in schools. In underscoring the necessity of early intervention and identification, Kessler et al., (2005) documented that adults with disabling mental health conditions experienced onset in early adolescence. The scope of need is great, few children receive organized services, and schools are a primary vehicle for identifying people who may face a lifetime of emotional and economic loss without effective treatment.

What Relationship has Existed Over Time Between the two Systems and how have they Evolved as Separate Entities?

During the course of the project, participants repeatedly discussed their frustration inside and between both systems. The commitment and dedication in both systems is high. That said, professionals we encountered were uniformly concerned that policy makers are not addressing, or do not understand, the barriers to building more effective services. Many of the professionals who participated in this work discussed individual successes they achieved with a child or family, or the creation of effective solutions within or across local systems. But they were quick to cite a host of systemic and institutional barriers that work against these often small and local successes. The parents with whom we spoke expressed support for many of the helpful individuals they had encountered in both systems, but shared similar frustrations.

The Public K–12 School System

Of the two systems addressing the mental health needs of children, the K–12 system has the longest history and set of traditions. In point of fact, there is a considerable literature that suggests the majority of mental health services provided to children are provided within the framework of K–12.

In the late 1800s, with repudiation of the use of adult jails to house wayward children, the public education system was seen as an important public institution to help turn children away from a life of indigence and crime. As discussed below, in the 1920s schools found common cause and began linking efforts with Child Guidance Centers and Juvenile Courts. This relationship resulted in

adaptation of multidisciplinary team concepts with children who were encountering multiple difficulties, especially in school adjustment and success.

Over the next 40 years, education reformers documented the multiple challenges experienced by an education system that was neither prepared nor funded to address the many barriers poor children encountered as they entered the public education system. In 1965, the United States Congress responded with the Elementary and Secondary Education Act (ESEA). The central intent of the act was to create stronger linkages between schools, poor communities, and to increase capacity to mitigate the negative impact of poverty on educational attainment. The funding stream developed from this federal commitment was Title I.

While ESEA was a significant step forward, reformers and advocates continued to be concerned about the ability of marginalized populations to experience the benefits of a public education. Specific concerns included the costs of providing public education to large numbers of disabled and mentally ill individuals and in support of the goal to move this population out of institutional environments, IDEA was passed in 1975. For the second time, the federal government recognized a major role it should play in funding education services for a marginalized population. The services associated with IDEA are broadly referred to as special education in the K–12 system. It should be noted that despite the development of federal support to children with disabilities and severe emotional disturbances, the allocation of those resources is limited to 12.7 percent of student enrollment.

These reform measures notwithstanding, policy makers and others continued to be concerned about a growing achievement gap. Compared to other developed countries, children in the United States were regarded as less prepared to succeed in a globalizing economy. *A Nation at Risk* was published in 1983 and served to galvanize reformer/advocates within the growing testing and measurement movement. The book's message and the national political debate it fueled, came to a head in 1994 with reauthorization of the ESEA. In it, Congress established the principle of performance based education and required states to develop measures to use in judging the achievement of adequate yearly progress. The 2002 passage of No Child Left Behind (NCLB) incorporated a series of reform strategies that had been discussed since the early 1980s by restating and formalizing expectations that states were obliged to meet. It also clarified performance accountability for schools. Despite the fact that NCLB was seen as a victory by many reformers, others felt that federal budget allocations in 2003 and 2004 were inconsistent with promises made in 2002. Further, many K–12 professionals and their political advocates cite state revenue shortfalls during those same years as a principle hardship and barrier to implementation of the federal law.

It is in this environment that schools are confronted with the need to remove barriers to learning, increase student achievement, mitigate truancy, and reduce

drop outs. The mental health needs and behavioral challenges of students are principal issues to be addressed in order to achieve these performance goals.

The Publicly Funded Mental Health System of Care

Similar reform developments have occurred over time inside the much smaller publicly funded mental health system. While approaches to formal children's mental health services have their antecedents in the K–12 system at the turn of the 20th century, they were later embedded in the Child Guidance Clinic Movement of the 1920s. Fifty years later, the overall approach to the conceptualization of children's mental health services was overtaken in the mid 1970s by the application of financing strategies which emerged from the physical health care system and had the effect of establishing the medical model approach to the organization and delivery of services. As this approach to financing began to shape change in delivery systems, a small group of advocates, including Jane Knitzer, an educator, stimulated the broader advocacy community by proposing the development of an integrated, child and family focused care system. In *Unclaimed Children*, Knitzer (1982) cited the problems associated with the neglect of mental health in children, including the fact that only 17 percent of community mental health resources were being spent on children. Her work, and that of her colleagues, spawned the creation of Systems of Care, characterized by Wraparound services and driven by a core set of principles (Exhibit 6).

In the late 1980s managed care principles were applied to financing of public mental health in the attempt to curb the growth of expenditures in the largely adult focused mental health system. While the work of Knitzer and her colleagues was widely embraced and identified as a promising approach by the federal Substance Abuse and Mental Health Services Administration, progress in the public system toward development and funding of child centered and family focused services stalled. The larger public mental health system continues to be primarily focused on the adult population.

Beginning in 1993, the federal government granted a waiver to the state which, consistent with managed care principles, allowed the state to invest Medicaid savings into services for non-Medicaid eligible individuals with mental health needs. Small economies of scale developed which created flexibility and an increase in services to an underserved population. This changed in 2003 when the Center for Medicare and Medicaid Services promulgated new regulations for the operation of Medicaid managed care plans and limited use of federal Title XIX resources. This change had corresponding negative impacts on clients and to the economies of scale which had been previously achieved within the system. While the state legislature took action to restore a portion of these resources, they prioritized the state's crisis response, involuntary treatment, inpatient psychiatric, and residential systems as highest priorities for expenditure. The outpatient mental health system was fifth in the scheme of priorities.

Many of the mental health providers we spoke with stated that while they continue to attempt to work in conjunction with K–12 to provide services to children, the flexibility that existed prior to 2003 has been eliminated. Given funding constraints, and the statutory responsibility of the system to focus exclusively on individuals with the most serious and chronic diagnosable illnesses, any vestige of capacity to participate in the delivery of expanded services or early intervention no longer exists through the Medicaid financing system. Where capacity has been built, it has depended on alternative solutions developed at the local level.

III. What is the Current Status of the Relationship Between the Publicly Funded Mental Health and Education Systems in Washington?

During the course of this project we found many examples of strong relationships and high levels of common cause in both systems on behalf of children with mental health needs. Throughout the state, individuals and groups meet regularly to discover how to create service structures to support engagement and response to children. Though language is often different, professionals in both systems recognize the complexity of the bio-psycho-social needs of children who experience, or are at risk of severe emotional disturbances. Professionals also understand the impact of these challenges to successful participation in K–12 settings. Given the scope of need that motivates these efforts, discussions are typically fraught with shared frustration at the rigidity of funding streams and the exclusionary rules that govern access to service. Professionals in both systems refer regularly to the “silo’d” or “stove-piped” nature of systems in both public mental health and K–12.

There are many promising collaborative efforts. But that is not to say that good relationships, or any relationship, between these systems exists everywhere. They do not. Some school districts have created capacity within their own revenues to address mental illness issues largely independent of the Medicaid mental health system. Also, some districts are too rural or small to have much access to public mental health services or to easily establish strong working relationships. In two instances, we found districts in remote areas that contract with private therapists to “help maintain deep end IEP kids in (public) mental health services” which are provided by small agencies that were equally remote. In some locations the relationship is little more than awareness of a phone number that leads to a mental health agency. Generally speaking, we found that some level of working relationship exists between public mental health providers, and K–12 with children who are formally identified in Special Education and, less frequently, when the occasional 504 plan requires it.

In describing the current state of collaboration between the public mental health and K–12 systems, interviews with representatives across the state indicate the following:

- Where we found collaborative program development and service, all but one depended on the availability of multiple streams of funding. The majority of these funding solutions were relatively small and dependent on special grants and/or included some contribution from school districts where limited flexible funds were identified.
- Those collaboratively developed efforts that showed the greatest promise for stability and expansion always involved significant levels of support from county or city revenue streams.
- In instances where large federal grants have been employed to bring additional resources into schools, such as Safe Schools Healthy Students, we found few examples where significant levels of service had been

- sustained. Where system change had been a major goal, we found only modest achievements.
- We found one moderately sized program which operates inside schools and by becoming a Title XIX contract provider is supported almost entirely with Medicaid funds.

What do Professionals and Parents Say About Successful Relationships Between Public Mental Health and Schools?

Interviews completed with professionals from both systems, and parents who had significant experience in both systems, revealed a variety of themes.

The relationship between the two systems is typically driven by eligibility and diagnostic criteria which restrict the numbers of children served to those with the most severe functional impairments.

The publicly funded mental health system has no capacity to serve in an early intervention role. While the system does respond to crisis, and provide crisis stabilization services, unless a child can be enrolled in Medicaid and meets Access to Care Standards, the intervention from the public mental health system is brief. While consultation often occurs with schools during these brief interventions to assist in the child's return or readjustment, it too is brief. This depends almost wholly on the service capacity of the mental health provider and the practical limitations of access and follow through, particularly in remote, rural communities. We were told that acceptance of this reality is helpful to establishing and maintaining relationship.

Where the relationship between the two systems appears most robust the two systems have found ways to bring mental health services into schools through application of multiple, if small, funding streams that expand service provision beyond the limitations of access to care and the Medicaid population.

There are multiple examples of public mental health services being delivered in schools. That service appears most effective when both systems have found ways to create economies of scale through the use of non-Medicaid resources, creating capacity for the mental health therapist to serve children who do not meet access to care criteria. We found multiple examples of how this might be achieved. But these arrangements are often precarious, year to year, and usually difficult to sustain especially in poorer, remote locales. Non-Medicaid resources used for this purpose usually include pooled funds from school districts, city or county revenues, small grants, and occasional support from the philanthropic community.

The current national movement to establish School-Based Health Centers (SBHC) is an example of how schools have worked with political entities to develop more comprehensive approaches to service delivery. While the

public mental health system is not always able to directly participate in these funding arrangements, Medicaid is a significant payer for these SBHC services.

Wraparound teams and Multi-Disciplinary Teams (MDT), whether led by a school counselor or mental health therapist, are cited as useful strategies for removing barriers and increasing communication.

In fast moving environments where the workload is high and time is as scarce as financial resources, communication within and across systems is as essential as it is difficult to maintain. In order for these communication mechanisms to succeed, they must be predictable and purposeful. They must be regularly scheduled, attended, agenda driven, and solution focused. While the purpose or function of Wraparound teams and MDTs may be slightly different, their success has common ingredients. The central intent of these structures is to remove communication barriers to planning and implementation, and to create involvement of those individuals closest to the child. Several mental health providers cited service driven reimbursement rules as a barrier to involvement in Wraparound processes when Medicaid was the only funding source.

School counselors are key.

We were told repeatedly that school counselors are usually the lynchpin in the successful delivery of mental health services with children in schools. While it is understood that not all schools have assigned counselors and others may be designated to carry those responsibilities, the function of the school counselors is central to successful delivery of service by a therapist or mental health case manager. Whether funded by Medicaid or other resources, therapists who understand the role and function of school counselors and are able to create alliances will increase opportunities for improved service delivery. The functions of the school counselor are essential to identification, assessment, coordination, communication, and follow through on behalf of children and K–12 educational management of student needs. Mental health therapists who succeed in providing service in the school environment understand they are guests, and that they work in support of a broad, complex system organized around a unique set of rules and operating principles. While there are multiple examples of counselors and therapists participating together in the delivery of services, the relationship between the two requires focused attention, constant communication, and a mutual respect for roles and limitations. In every instance we found where mental health services were successfully delivered in schools by a community mental health agency, these relationship skills between counselors and therapists were the bedrock of that success.

School nurses play an essential role in delivering publicly funded mental health services.

School nurses are frequently involved in the assessment, management, and referral of children who are demonstrating behavioral or emotional problems which raise questions about their health and well being and interfere with their ability to adjust within the school setting. Nursing staff manage medication, help maintain relationships with family members, and function as a central member of the school team which works with the child and family to modify behaviors. Nurses are often involved in coordination with mental health service providers or serve as school liaisons within Wraparound teams. They are an indispensable link within the framework of providers who are seeking to provide mental health services to children and their families.

The direct involvement and consent of parents is essential to success. Communication must be thorough and consistent.

During multiple discussions among Advisory Committee members and interviews across the range of project participants, there was unanimity about the central role of parents in the delivery and integration of mental health services in schools. This emphasis on the central role of parents in successful treatment is also a central finding in the mental health and education literature. Success in engaging children in mental health and education services is almost always dependent on the degree to which parents are involved and their expertise is respected. Professionals in both systems acknowledged that a parent working as an advocate for their child often risks being viewed as a parent who is an adversary of the system, whether the system is K–12 or mental health. Programs that successfully deliver services to children with disabilities or severe emotional disturbances have learned to embrace parents as central partners in this process. Schedules are arranged beyond the confines of the school day to maximize parent access. The involvement of parents can help systems navigate Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) rules. In the context of delivering “Wraparound” services, the principle of parental involvement is central to the management of service goal definition and service delivery. Within the state there are multiple parent support programs designed to assist parents in finding appropriate services for their children. While they are not present everywhere, they are frequently embedded in the fabric of relationship between K–12 and mental health. In some locales, these parent support entities have been instrumental in weaving the fabric of that relationship.

Relationship is everything.

Virtually every person with whom we spoke who was knowledgeable about developing connectivity and collaborative structures to enhance

coordination between the public mental health and education systems shared a common belief. Relationship between individuals is everything. Several comments are worth repeating. Where a relationship had been developed and sustained to deliver mental health services in schools which were extended to children who did not meet access to care or Medicaid eligibility, there were often high levels of respect between districts and mental health agencies. "Good relationships make it easier to keep the problems in some perspective." "They (mental health) seem to want to be helpful but can't. Good relationships exist at the individual level." One comment made by a senior mental health administrator summarized several statements made by others. "There's nothing systemic about any of this. Good things happen between mental health and schools because of the work of individuals."

What Examples Exist of Promising Programs?

In our attempt to identify promising programs, we first sought the advice of the Advisory Committee. Second, we contacted many of the individuals who had responded with interest to an original OSPI notification that this project was being undertaken and we sought their expertise. Third, we attempted to recontact the agencies/programs that had been identified in an earlier OSPI effort in 2003 to identify promising programs across the state (Exhibit 7). While some of those identified in 2003 are thriving and listed here again, others no longer exist or have significantly reduced capacity in the past four years. Successful contacts with some of those individuals led to discussions with others. Fourth, we contacted more than 160 school districts requesting their participation in a telephone and email interview process to learn about what relationships existed with the mental health system and what programs may be operating within schools that address the mental health needs of children.

This list of programs and agencies does not account for all programs in the state where mental health providers and schools coordinate or collaborate in the delivery of services to children with severe emotional disturbances. Because of the essentially local nature of these mental health and school collaborative efforts, some valuable programs certainly were not identified in our search. But whatever their size or capacity, these programs do represent an array of approaches to service and funding solutions. Those programs funded solely by Medicaid can only serve the Medicaid population. Programs with other sources of funds may have capacity to serve children who do not meet access to care criteria or are otherwise ineligible for service. Programs recommended as potential models for other communities through this review include:

- School-based mental health services: Family Services Spokane: Funded jointly by RSN/Medicaid and Spokane's East Valley School District. (509) 838-4128

- School-Based Health Centers (SBHC) in Seattle: Funding sources include City of Seattle and multiple health insurance companies including Medicaid. Seattle Public Schools provide facilities.
(206) 296-4987
- Family Support Centers Program: Funded by Tacoma Health Department, Tacoma Public Schools, and Readiness to Learn.
(253) 571-1322
- Three Rivers Wraparound: Lutheran Community Services in Kennewick. Funding sources for this program include RSN/Medicaid, United Way, Children's Administration, and Lutheran Community Services.
(509) 334-1133
- Day Treatment Program, Discovery School: Located in Jefferson County Mental Health but funded by local school districts.
(360) 385-0321
- School-based mental health services: Spokane Public Schools as a licensed mental health agency, funded by RSN/Medicaid.
(509) 345-5900
- School-based mental health services: Greater Lakes Mental Health Center, funded by RSN/Medicaid and Clover Park School District.
(253) 620-5138
- At-risk intervention services: Skagit County Youth and Family Services, funded by county revenue, grants, multiple school districts, and Readiness to Learn.
(360) 336-9437
- School-based intervention services: Palouse Counseling Services, funded by RSN/Medicaid and Safe and Drug-Free Schools.
(509) 334-1133
- Parent/School support and advocacy: A Common Voice for Parents of Pierce County, funded by RSN/Federal Block Grant.
(253) 537-2145
- School-based mental health: Compass Mental Health, funded by RSN/Medicaid and Island County.
(360) 682-4141
- In-home services: Children's Home Society, Chelan County Consortium, funded by Readiness to Learn, United Way, and Developmental Disabilities.
(509) 663-0034

- School-based mental health services: Cascade Mental Health, funded by RSN/Medicaid and schools.
(360) 740-8848

This list reflects multiple examples of good work achieved through collaboration and cooperation between mental health and K–12. The best examples of successful relationship and work are those achieved in closest proximity with schools. Typically, those arrangements were achieved with multiple sources of funding, however small, and the service provided extended beyond the limits of Access to Care and other Medicaid criteria.

What do Professionals in Both Systems Cite as Barriers to Relationship and Service?

The interviews with public mental health leaders and their counterparts in K–12 education showed agreement about a variety of barriers.

The Access to Care Standards.

Of interviews completed with mental health professionals, most of whom were at the administrative level, about half saw these standards as a major barrier to service provision and about half did not. Of interviews completed with education professionals who had some familiarity with the standards, the majority saw these as a significant barrier to service. One mental health clinical director stated, “These standards are frustrating to schools because we can’t help much unless the behavior is off the charts.” Another mental health clinical director stated concern about educating districts about access criteria by saying, “If districts understand how narrow the system is, it might have the effect of reducing their referrals.” One Educational Service District nursing services program coordinator stated, “It’s often difficult to get kids in under Access to Care.” Many others had similar comments.

The Medicaid Waiver.

The narrowing of Medicaid rule structures in 2003 significantly reduced services. Two clinical directors spoke about the inability to fully participate in consultation, planning, and coordination related to Wraparound services. The inability to serve a parent with mental illness who is above 100 percent of FPL, while serving that parent’s child (who has a serious emotional disturbance) who is at or below 200 percent FPL, was cited as a barrier to service and the maintenance of good relationships. A senior administrator in the RSN system stated, “We had a robust program until Medicaid changed.” Others in the nonprofit sector agreed the new regulations that governed the waiver “changed everything.”

Children's Mental Health Work Force.

Personnel in both systems discussed the challenge of finding and keeping qualified mental health staff. While this comment was especially reflective of service delivery challenges in semi-urban and rural areas, the concern was not confined there. Mental health administrators spoke of frustration in finding employees with children's mental health certification. A senior administrator in one RSN cited the absence of a single children's mental health specialist in that entire region. Education and mental health administrators both discussed the absence of psychiatrists, especially in more rural areas. Many mental health providers shared frustration about the insufficiency of trained bilingual, bicultural mental health therapists and case managers.

Language Barriers: Lacking a Common Definition of "Mental Health."

Both systems spoke repeatedly about the absence of common orientation and language in their work together. As stated, the mental health profession is organized around diagnostic categories and the bio-psycho-social influences associated with mental illness. The K–12 system is less organized to the issue of causation than it is to the impact of particular behaviors on student learning and achievement. Moreover, professionals in both systems talk about the use of labels of convenience to qualify a child for needed service, while acknowledging the ethical issues associated with that practice. One individual with significant experience in both systems stated the concern in the form of a question. "Where does the behavior stop and the mental illness begin?" Still others, in both systems, spoke about mislabeling or misdiagnosing. One senior administrator in the K–12 system stated, "A lot of the kids labeled as learning disabled are not, strictly speaking, LD. They are behavior kids. No wonder they have behaviors; look at the patterns of violence these kids have experienced." A mental health administrator made a similar observation. "The ADHD label is overused because it is accessible. No matter how we cut it, it's all about the multiple disasters these kids experience before any of us are in a position to help."

IV. Given the Challenges we Face, How do we Move Forward?

During the last 25 years the mental health and K–12 literature related to children with mental health has moved down similar and often connected paths. The most prominent summative evaluations of this work have been produced by multiple consortia led by University of South Florida, the University of Maryland, and the University of California at Los Angeles. From these centers of activity have come a series of proposals for creation of a formal, long term agenda to create capacity within the K–12 system to respond to the mental health needs of children as the clearest path toward removing barriers to learning and increasing academic success.

In a 1989 report from Carnegie Council Task Force on Education of Young Adolescents, the council made the following statement, "School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge. " In the course of this project, we encountered no one who disagreed with that statement. The challenge is enhancing the resources and skills within the K–12 system to meet its responsibilities within the boundaries of its mission.

The nature of mental illness in childhood often involves its progressive emergence as children are unsuccessful in meeting key developmental milestones because of the emotional, behavioral, and cognitive challenges inherent in their illness. The resulting ambiguity about what is occurring and what is needed to help manage the problem throws school personnel and families into an often protracted process of problem solving with scant resources. The absence of capacity in other public systems to intervene early in a range of mental health problems children experience, places the K–12 system in the difficult position of responding when they are not fully equipped to meet the assessment and treatment demands of mentally ill students. This difficult and often prolonged process of discovery means that the K–12 system must often meet the "needs that directly affect learning" alone or in partnership with whatever mental health resources they can create.

While this process of engaging the problem of a child's mental health needs is often ambiguous, there are new methods and processes that school personnel can use to make this management challenge more coherent and productive. There are also established programs adapted to the school setting that provide an evidence-based tool kit for helping schools help children learn to the best of their ability despite the mental health challenges.

The major elements of this new approach include an evolution in considering response to special needs students (Response to Intervention), the development of integrated response models for mental health in schools, and a number of empirically-supported specific curricula and intervention programs which provide a continuum of potential actions to address mental health as a need that directly affects learning.

What is common to these approaches is acknowledgment that schools and parents are at the center of addressing mental health challenges to learning. Mental health professionals, including Title XIX mental health agencies, serve a critical integrated role but, this role must be in the context of a school-based response to improve learning outcomes.

With a focus on improving learning outcomes and the role of schools, these new approaches cannot be implemented to scale without addressing the fundamental resource question. The approaches outlined below do suggest some resource strategies but these strategies involve realignment of existing resources and the possibility of increased efficiencies. The universal opinion of the participants in this project is that the systems of response for mental health as a learning need are under-resourced. While the strategies that follow point us in a new direction, public policy and investment has to address the fundamental gap between need and response.

Rather than reproduce in detail a set of available resources, in the balance of this resource manual we summarize the logic of RTI and introduce related practices that form the basis for evidence-based and promising practices in implementing actions to address mental health in schools. We point the reader to the readily available resources that provide greater detail. In fall 2007, we recommend the following resources as essential tools for orienting to and adopting the practice recommendations from the field in school mental health:

- OSPI *Using Response to Intervention (RTI) for Washington's Students*
<http://www.k12.wa.us/CurriculumInstruct/pubdocs/RTI.pdf>
- *University of South Florida's School-based Mental Health: An Empirical Guide for Decision-Makers*
<http://rtckids.fmhi.usf.edu/rtcpubs/study04/SBMHfull.pdf>
- UCLA School Mental Health Center/Center for Mental Health in Schools
<http://smhp.psych.ucla.edu/resource.htm>
- National Technical Assistance Center on Positive Behavioral Interventions and Supports (PBIS) National Technical Assistance Center on Positive Behavioral Interventions and Supports (PBIS)
<http://www.pbis.org/main.htm>

V. What is Response to Intervention?

In 2004, the IDEA was amended and broadly introduced a conceptual approach to managing academic risk by proposing adoption of a Response to Intervention (RTI) process of assessment and remediation. Integrated into the 2004 reauthorization of IDEA, RTI provides a method of approaching all barriers to learning through a common strategy to all causes. While not originally intended for application to severe emotional disturbances in children, RTI was introduced to create an approach to screening, assessment, and intervention designed to identify and reverse patterns of academic failure.

Response to Intervention is a district and building level management strategy for organizing and delivering identification, assessment, and intervention that ensures all students receive the best educational interventions matched to individual need. In 2006, RTI was adopted in Washington State through OSPI as a principal method of approaching school performance planning. These ideas are at this time quite new and not in broad use across school districts. However, in the literature on school-based mental health, there is consensus that RTI and similar conceptual frameworks may offer the means to address problem solving in a logical manner. These frameworks align with evidence-based practices which unify the approach to educating special needs children with education practices targeted to all children.

The concept of RTI closely mirrors the extensively tested public health conceptual model which identifies three levels of population based interventions designed to prevent the progression of illnesses or problematic behaviors. This conceptual approach has been the structure in which most of the public health gains of the past century have occurred. In public health, this continuum was described for decades as a continuum from primary prevention (increasing healthy behaviors in people without known risk) to secondary prevention (increasing health in people with early indications of illness risk) to tertiary prevention (management of established illnesses to maximize the health of affected people). Recently, prevention theory has been reworked in a “needs defined” continuum of response to problems that includes formal interventions for problems as one element of a range of actions (Institute of Medicine, 1994). In this model, prevention actions are delivered through an integrated effort in the community or school that include:

1. Services to “universal audiences” to protect against the emergence of problems.
2. Services to “selective audiences” to reduce risk of the development of problems in people with known vulnerabilities.
3. Services to “indicated audiences” who already have been exposed to injury.

Prevention activities are built on a common set of education and behavior principles, but the nature of the intervention (intensity, duration, complexity, and

definition of benefit) is determined by the level of individual risk, need, and level of formal consent for treatment.

RTI involves adopting a method of planning within schools' comprehensive plans. Adoption of RTI likely will involve major shifts in approach to staff roles and the planning process. As a result, the first step in implementation is developing an administrative and staff consensus to align practice to RTI principles. Schools and districts are asked to adopt training goals, team development, and realignment of existing resources to support the RTI process. OSPI provides a useful planning document to help schools evaluate and begin the process of adoption of RTI. The following key elements are adapted from this OSPI resource.

RTI organizes practice around three principles:

- High quality instruction and intervention, learning rate and level of performance, and data driven decision making.
- Learning rate and performance refer to monitoring of progress against baselines for the intervention and against peer typical progress to guide determination of the success of the intervention.
- Data driven decision making means that schools have to progressively align action to objective standards of progress.

High quality choices refer to evidence-based practice wherever possible. These three principles are universally applied but as children fail to meet learning benchmarks, the intensity, formality, individualization, and resource commitment of resulting school actions increases with the aim of resolving or ameliorating the child's learning and behavioral problems.

Under IDEA, RTI can be applied as an assessment and management process that leads children to qualify for special education services. But, RTI defines a continuum of response which is fundamentally intended to address problems whenever possible before learning and behavior deficits progress to the point that special education referral is necessary, or if the needs of a child are so severe, expedites the early and effective use of special education as a critical learning resource.

RTI core practice guidelines are:

- All educational resources are applied to the education of all students.
- The choice of curricula and interventions for all students is based on empirically-supported programs.
- Screening, assessment, and monitoring of need and progress is based on valid and objective assessment criteria and tools.
- Students are supported through a set of tiered responses in which the assessment and intervention strategies progressively are more targeted and intensive to meet increasing need.
- At every significant decision point, parents are engaged as full partners.
- At every major decision point, decisions are based on data not opinion.

RTI requires a systematic approach to children to support academic achievement in a cycle of learning, managing, and improving response. This standard treatment protocol (OSPI) ensures student decisions universally are planned and recorded, involve specific curricula and strategies, and measures progress against formal timelines. Most of this is deeply integrated into standard K–12 practice. But the emphasis in RTI is seeing these normal curriculum planning and documentation steps as integrated sources of information used in the systematic identification of children who may not be making adequate progress.

TIER I

RTI involves a three tiered system of response. Tier I involves universal activities for all students with an emphasis on the highest standards for curricula and student development programs based on available research. The Tier I activities are organized around a core set of goals for the development of all students but these core goals also form the goals and decision-making scaffold for actions that may involve more specialized and intensive individual services. As a result, the goals of universal Tier I activities are aligned fully with more specialized services for students not making adequate progress. Tier I interventions include strong core educational curricula, school climate and quality of school life interventions, and universal social and behavioral skills education like conflict management skills.

TIER II

Tier II interventions are supplemental to universal school interventions defined in Tier I and begin to target resources to students not making typical progress academically, socially, or behaviorally. Tier II activities are typically delivered in small group programs, are relatively short in duration (9–12 weeks), and involve frequent monitoring of progress. The ideal is that short targeted interventions stabilize many students, address barriers to learning, and permit them to benefit fully from universal school educational programs. However, if students do not show improvement in Tier II activities, they may cycle through additional Tier II strategies or be identified for movement to Tier III level supports.

TIER III

Tier III RTI interventions are applied when it is clear that student progress is a significant concern, and the student has not benefited from less intensive Tier II interventions. Pathways into Tier III RTI responses for behavioral and mental health concerns typically involve either a crisis of behavior or progressive problems with achievement that need to be assessed so that appropriate interventions can be developed. Crises present an immediate point of opportunity for coordination between schools and mental health provider agencies. All children in Washington State have the right to crisis intervention services. Part of effective RTI system development can include the protocol development with mental health providers for the effective and prompt use of

these services. The frustration expressed was when the level of crisis support from Title XIX providers could not be sustained but the needs of the child, family, and school continued. RTI presents a structure within which crisis management resources may be employed and realistically managed.

Tier III activities are more likely to involve individual or small student group activities, be longer in duration (9–12 weeks), with the goal again of stabilizing and improving the capability of individual students in need who demonstrate benefit from more universal supports. The optimal outcome is the return of the student to typical progress supported by universal school strategies and/or universal and Tier II supports. When Tier III interventions do not result in the resolution of the student's challenge to adequate progress, maintenance of Tier III interventions, referral to special education, or referral to 504 planning are the recommended actions. Special education services and 504 plans provide in effect the fourth "tier" of the RTI continuum of response. Critically, RTI involves a systematic series of remedial steps prior to the use of special education as a school resource.

We would suggest that given eligibility constraints in the Title XIX mental health system, it is when students do not profit from Tier II activities related to emotional and behavioral needs that alliances with mental health professionals are likely to be most productive and sustained. If students meet Access to Care Standards, conjoint treatment and education goal setting and planning, integration of mental health services into IEP and 504 planning are steps that can support overall intervention success. Again, RTI principles would lead us to view building these protocols systemically rather than child-by-child as the appropriate goal under school comprehensive plans. Mental health providers external to the school can, with parental consent, also be important assessment and support aids in Tier II and Tier III interventions when a child has a preexisting mental health disorder but is only recently beginning to show the learning problems that require additional attention.

Parents are pivotal at all levels of RTI but how they are integrated practically often falls short of the value they add. We would suggest some natural points of alliance between schools and parents/caregivers. First, caregivers are the critical source of information for effective assessment of need. Second, in most Tier II and Tier III interventions, caregiver informed consent will be required, and gaining informed consent presents an opportunity to extend the educational and support goals of Tier II and Tier III programs. Third, the behavioral and mental health needs of students rarely are isolated to the student as an individual. With full recognition of the mission and boundaries of schools, effective assessment and intervention planning will routinely involve assessment of parental and family resource and referral needs in support of the students' learning goals. Finally, engaging the parent fully as a partner in the wellbeing of the child is an integral part of many of the evidence-based practices referenced below. Practical and ethical demands move parents to the center of RTI planning.

Tier II and Tier III interventions minimally involve the realignment of existing services but may also require identification or reprioritization of school resources on a scale that is effective in improving overall school outcomes. A number of the Washington State programs identified in this document have developed alliances with public mental health agencies to support Tier II and Tier III services while others have developed the internal capacity to support these services through school-based nurses, counselors, and psychologists. Resource strategies for expansion of services have achieved some modest but clear success. These strategies involved expanding resources by strategic use of grant programs, pooling resources across multiple schools or districts, reprioritizing fixed resources within the district, and creating new local funding through city or county investment. None of the programs felt the capacity they developed addressed the need but there are successful, if modest, models of how the resource problem has been at least partially addressed.

As a data driven strategy, RTI embraces universal screening in education as a fundamental step to guide decision making. RTI is not prescriptive about decision making but argues that we have to change the strategy of waiting for deficits to emerge before we respond. Screening all students on a regular basis is fundamental to proactive identification and early intervention. The logical companion step for schools is routine monitoring of progress of individual students. In this information guided strategy, RTI does not distinguish typically developing and special needs children. Rather, the first principle of “all education resources applied to all students” is utilized in screening and monitoring of progress. As a practical step in adoption of RTI, schools have to evaluate their existing information management systems and staff literacy in use of information. Information system development to support universal screening and monitoring of progress is a priority goal in the school’s comprehensive plan if RTI is to be effectively adopted.

The development of the assessment system to support RTI aligns well with the general movement to performance-based decision making in K–12. RTI applications involve universal screening and monitoring of academic and social/behavioral development as a foundation for planning. From this foundation of routine assessment, diagnostic and targeted assessment of specific program implementation are used to “drill deeper” and understand the need and progress of children based on their struggle to progress at an adequate individual pace and in line with their developmental peers. The implication in adoption of RTI practice is that the management of more intensive and targeted assessment is a resource applied as a phased data collection step to support planning and not solely for the purpose of qualifying individual children for special education.

In general terms, 80 percent to 90 percent of the population is able to benefit from “universal” prevention approaches. In schools, these universal mental health strategies involve adjustments to school climate that create an environment supportive of safety, mutual respect, and fostering of self-respect and self-efficacy in all students. Collectively, these activities contribute to the

level of school connectedness students experience. In the school dropout and truancy literatures, these school climate issues are predictive of individual student adjustment. The balance of the child population may need more direct support adjusted for the level of demonstrated need or vulnerability. Among other students with progressively more demanding needs, 5 percent to 15 percent of the group may benefit from a more targeted intervention because there is a clear need and risk of the problem progressing into a more chronic concern, while 1 percent to 7 percent may require increased levels of service and sustained support because the level of indicated need is extremely high and less intensive and intrusive solutions have not succeeded (Sugai et al., 2002).

RTI is a planning structure that lays out a resource management and goal-driven decision making process aligned with the common mission of schools. In RTI, mental health needs are one aspect of this fundamental management to mission responsibility of schools. RTI does not direct schools to specific methods but rather to standards and procedures to guide decision making. Fortunately, in recent years several closely related mental health in schools development strategies have emerged with strong empirical supports but much more targeted recommendations about the conceptual and programmatic tools available to schools. These resources are significant for putting flesh on the bone of RTI and its application to mental health in schools.

Currently some essential resources for any school or district addressing mental health in an RTI context include the work addressing Positive Behavior Interventions and Supports, the resource guides of the UCLA Center for Mental Health in Schools, and the conceptual work of the University of South Florida. These resources are readily available on the Internet and we have chosen not to reproduce them here but to recommend them as the next step beyond this document.

Finally, while new work emerges every year, there is now a set of empirically supported school-based programs available for integration with the three tier RTI model for provision of phased interventions. Access to these programs is also readily available on the Internet. Detailed descriptions, analysis of their research support, and directions to authors and publishers are available. We have again chosen to direct readers to these extensive resources rather than reproduce them in this document.

Key resource Web sites are:

- SAMHSA Model Programs
<http://www.modelprograms.samhsa.gov/>
- U.S. Department of Education What Works Clearinghouse
<http://ies.ed.gov/ncee/wwc/>

Are There Performance Goals to Which Both Systems Can Aspire?

The 2003 *Examples of Activities That Promote Promising Practices* (Exhibit 7) was developed with the intent of guiding developmental movement across both systems. The Advisory Committee felt it contained important elements associated with creating effective collaborations between mental health services and schools. However, the committee was concerned that in the face of current capacity limitations and fragmentation within the systems, several of the elements in the document may be overly ambitious and global. But rather than discard or replace the 2003 document, the committee was unanimous in its support of recommending a clearer emphasis on practices associated with the delivery of mental health services in closest possible proximity with schools.

The movement toward establishing SBHCs is influencing how school-based services are conceptualized and how infrastructure is developed. In the spring of 2007, the National Assembly on School-Based Health Care developed a Planning and Evaluation Template to apply to delivery of mental health care in schools (Exhibit 8). While this document is as ambitious as the 2003 *Promote Promising Practices* document, it is more specific in its focus on K–12 and clearer in the identification of steps to be taken toward establishment of mental health services in schools. While there is some overlap between the two approaches, such as emphasizing the role of parents in the delivery of mental health care, the emphasis is different and more targeted to integration of services in K–12 environments.

The committee's recommendation is that these documents be used in tandem.

RTI can represent a framework for shared performance goals. Tier II and Tier III interventions create a framework for schools to determine if they want to partner for delivery of these services or build internal capacity. If the decision is to partner, then mental health providers, including Title XIX mental health agencies, represent significant content expertise in the development and delivery of these targeted services. For mental health agencies, the ability to have small to medium sized contracts can be a critical part of expanding their mission and presence in the community as not for profit agencies.

VI. Review of Literature

In the review of literature (Exhibit 9), the effort was made to identify the best and most current information related to financing, directions for policy and program development, and evidence-based intervention strategies related to the relationship between mental health and schools. The Advisory Committee asked that specific attention be given to the issue of parent and family engagement. Though none of the articles included in this review have titles that direct the reader's attention to the specific topic of parent engagement, the central importance of this matter is thoroughly embedded in many of the cited articles and papers.

Exhibit 1

Minutes of the Advisory Committee

**RTI Advisory Board Meeting
C.H.E.F. Center, SeaTac
Friday, May 25, 2007**

Meeting Minutes

Members Present:

David Crump

Coordinator
Spokane Public Schools

Karen Trayler

Parent

Marge Critchlow

Parent
A Common Voice

Terry Knowles

Education Specialist
Clover Park School District

Jack A. Maris

Vice President
CWCMH

Ann Allen

Director
ESD 105 (Yakima)

Abbie Pack

Asst. Director of Special Ed.
South Kitsap School District

Kelli Hoekstra

Program Manager
PSED

Kris Rathbun

Program Manager
Clarkston School District

Melissa Robbins

Mental Health Coordination
Vancouver School District

Tracy Wilson

Asst. Director Special Ed.
Pasco Schools

Teresa Wright

Director
Youth and Family
Spokane Public Schools

Chris Tobey

Superintendent
Youth and Family Services
Skagit County

TJ Cosgrove

Program Manager
Seattle/King County Health
Department

Teague Griffith

Coordinator
Spokane Washington State University

Mike Hickman

Assistant Superintendent
ESD 113

Roy Harrington

Senior Research Associate
Washington State University—Spokane

Roy Harrington framed the groups tasks by reviewing the Statement of Work, the intent of the Project, its relationship to legislation and other work from 2003, the involvement/oversight of the Mental Health Transformation Grant, and materials which have been developed to date. Ron Hertel from OSPI is the Program Manager for this project with a co-partnership inside the DSHS Mental Health Division with Judy Gosney.

RCW 71.36.040(3) requires OSPI and DSHS to “jointly identify school districts where mental health and education systems coordinate services and resources to provide public mental health care for children.” Further, the RCW requires OSPI and DSHS to “work together to share information about these approaches with other school districts, RSNs, and state agencies.”

It’s the purpose of this project is to fulfill those requirements as outlined in the Statement of Work which contains several deliverables.

1. Convene an Advisory Group to modify, refine and rework two documents which were used in 2003 to gather information about mental health services that are provided in schools across the state. Meetings of the Advisory Committee related to this purpose are to be concluded by June 30, 2007.
2. Complete a literature review of accepted best practices associated with the delivery of mental health services in schools and identify current information about the use of RTI principles/practices that focus on the mental health/student performance relationship and address student mental health needs.
3. Create a resource manual that reflects the findings associated with number two above and submit a draft to OSPI by July 15, 2007.
4. Develop and broadly disseminate informational material designed to recruit potential trainers, representative of education, mental health and appropriate others.
5. In consultation with the Advisory Committee, develop a strategy and implementation plan, using the train-the-trainers approach. To deliver curriculum developed to share the resource manual, and disseminate information about best practices/promising approaches for the delivery of mental health services in Washington’s schools. The curriculum will include a subsection devoted to the use of RTI principles in the delivery of mental health services.
6. The training shall take place in each of the nine geographical ESD regions in the state and shall be delivered to a minimum of 100 individuals.
7. The project will submit a call for presenters proposal for the 2008 OSPI conference.
8. At the conclusion of the project, a report will be submitted to OSPI that describes project success and achieved scope. The report is to include a subsection focused on the policy implications of the work completed.

While the SOW specifies additional details and due dates related to the project, these are the primary highlights:

Each of the Advisory Committee members has a copy of the SOW.

To begin the discussion, the committee identified four groups of students that are relevant to the discussion of mental health services and schools.

Group one: Has medical coupon (Title XIX-Medicaid) and meets the Access to Care Standards as to the severity and chronicity of problems.

Group two: Has medical coupon but doesn't meet Access to Care Standards.

Group three: No medical coupon and no health care coverage.

Group four: This is a child with private health care/insurance. While this group may seem to come from families with resources to address mental health concerns, schools often encounter barriers to service. Some examples of common obstacles are:

- Private insurance for MH care is usually not comprehensive and benefits are often used up very rapidly.
- Health Insurance Portability and Accountability Act (HIPAA) and the Federal Educational Rights and Privacy Act (FERPA) are statutes that must be accounted for in accessing service.
- Some families with coverage are unable to access care due to cost of co-pays.

While the outline of the Statement of Work identifies the focus of work to Category one, it is difficult to engage meaningful discussion about the issue of mental health in schools if the other three categories are ignored. A focus solely on the first category in the context of the statement of work may serve to identify promising and evidence based practices implemented as a result of collaboration between schools and the Medicaid/mental health system, but additional promising and evidence based practices have been developed at the local level as a result of K–12 collaborations with local government and private sector funding sources to serve the mental health needs of some children, particularly in categories two and three.

The group recognized a series of overall constraints within systems which create significant barriers to the development of adequate mental health services in schools.

- Multiple program development/demonstration grant opportunities (e.g. Safe School Healthy Students) are used to create promising or evidence based practices within schools. It is usually the case that services created are not sustainable within the current funding climate.
- Schools are seeing more and more children in crisis and, invariably, each of them have a family in crises.
- Mental health issues in these children, by definition, must be addressed before teachers have a chance to address learning.
- Schools clustered around military bases are watching kids fall apart on a daily basis.

- Teachers must be trained to understand they are teaching to kids who are in crises.
- Existing funding streams in either K–12 or the MH systems are not responsive to these issues.

It was suggested that three broad issues be considered in approaching this work. The first is to address the lack of clarity that exists within the K–12 and Medicaid/mental health relationship and create curriculum to make those realities as transparent as possible. There are current examples of good work that's been achieved in schools using the Medicaid/mental health funding stream and those should be identified and described. The second is to describe other collaborative financing methods that have been developed within districts to create capacity to serve mental health needs of students. The third is to identify issues within the K–12 and Mental Health relationship, whether practical or philosophical, that can interfere with creating capacity. Recognizing and understanding those may help create a roadmap for proceeding with this task and making policy recommendations at the conclusion of this work.

There was a brief discussion about resources the group might like to refer to as it forms an approach to the work. Those included referencing the work of E.M. Rogers and his 1962 work Diffusion of Innovations, Malcolm Gladwell's 2000 book The Tipping Point, the UCLA Center for Mental Health in Schools Web site, and the Minnesota Center Against Violence and Abuse (MINCAVA) Web site. The latter two are probably the broadest and deepest Web sites available related to those issues that shape context for this project.

The group then began a general discussion about a series of practical issues that must be considered as curriculum is developed and as an approach to training/implementation is shaped.

- How will presenters of curriculum be received by the audience? This may vary from building to building and may depend on the credentials of the presenter.
- How will presenters know what the audience knows—who is the target audience?
- There was consensus among the group that most K–12 personnel do not understand how to access the public system. They have no idea about the meaning of Access to Care, and are often frustrated in the process of getting students into services.
- It was suggested that some of the training be targeted to K–12 policy level personnel and that some of the trainers should be policy level staff. Some school districts have had issues with their RSN.
- It is felt that application of Access to Care Standards varies from RSN to RSN and from service agency to service agency. Part of the task is to create complete transparency around this issue for school personnel and for parents.

- The group wondered if data was available, what percent of children referred actually meet Access to Care Standards. (RSN's and the Mental Health Division have data about who is referred and whether they get into the system, but there probably is no clear/consistent data associated with which district facilitated a referral. Districts have no consistent data about the level of unmet need).
- Training must help create clarity around FERPA and HIPAA and how these two sets of confidentiality regulations interact.
- The final question raised regarding the train-the-trainer curriculum is, what is the benefit? If there is no perceived benefit, finding an audience will be difficult.

The group commented about the tight timeframe for project deliverables, especially in light of the need to interview district personnel who will be existing for much of the summer in late June. That said, the group agreed to work to the timelines and only ask for extensions if due dates were crowded by the realities of the work or inability to contact and interview key informants.

One of the central issues that must be accounted for as this project gets underway, is the central role of parents in achieving student success, especially when students are confronted with multiple problems that do not easily fit into either the K–12 or mental health service paradigms. Parents are often in the position of being forced advocate into both systems on behalf of their children, and it is often that the role of “advocate” is seen as “adversary.” It was also acknowledged that while the position is difficult and uncomfortable parents who have the skill and determination to challenge systems, it is often an impossible task for a large number of parents who do not have that requisite skill and competence. Parents say they are often told by both K–12 and mental health personnel who the professionals are and that parents should defer to those professional judgments. This issue is complicated by the fact that schools have responsibility for all children irrespective of the issues those children bring into the educational setting, and the publicly funded mental health system is only responsible for that fraction of children who meet short term emergency criteria or the relatively stringent Access to Care Standards. Thus parents, school personnel, and mental health personnel are often in positions where there is conflict among varying sets of expectation, need, regulation, and funding in environments where the accountability expectancies are extraordinarily high, despite diminishing resource levels in some school and mental health agencies.

The group discussed a variety of challenges within the foregoing context.

- Targeting schools for training and awareness building is one thing, but including others (i.e. parents) can increase the complexity of the training challenge.

- Attempting to discuss realities associated with obtaining adequate service within categorical Title XIX funding framework in the face of WASL expectations may create a sense of dissonance for K–12 staff.
- In some locations there have been role conflicts/territoriality between school-based mental health therapists and school counselors.
- In some locations there is concern that if mental health services are provided within schools a precedent is set whereby schools become responsible for the delivery of mental health services.
- Understanding building cultures is essential in creating capacity for the delivery of mental health services in schools.
- Even when schools achieve success in engaging families in the process of referral for services, many families are unable to follow through and children remain unserved.
- While many schools have embraced the role of parents as a necessary ingredient in addressing mental health needs of students, many parents continue to experience difficulty.

Notwithstanding the multiple challenges that exist within the system, or because of them, there appears to be a growing interest in the overall K–12 system to increase engagement with the social/emotional dimension of students. There is growing recognition that creating more effective/stronger relationships with “challenging” students it is not likely that test scores will improve, or that trancies and dropouts will be abated. The accountability pressures to improve test scores seems to be creating greater openness to recognizing the multiple behavioral and emotional dimensions students bring with them to schools daily.

In terms of identifying targets of opportunity for the training and how to approach them the group generated several ideas:

- In order to achieve success, the train-the-trainers curriculum must include teaching mental health providers how to approach the K–12 system, and then teaching the K–12 system how to approach the mental health system.
- Discussion/training about mental health services has to create transparency around the Medicaid system in each jurisdiction, including specific, honest discussion about local service capacity.
- Presentation must be broadly relevant to the issue of the mental health needs of many students, not just those fortunate enough to receive Medicaid services.
- There is no substitute for informal dialogue as a way to decrease barriers.
- Understand that WASL pressure has created greater willingness and openness.
- Identify which school communities have strong “parent partner” committees and use their experience to inform curriculum work. Might be wise to pilot curriculum there as well.

- Present the curriculum as another resource to use in working with students.
- Begin with communities that have a pattern of collaborative relationships where multiple agencies have credibility with one another.
- Understand how it is local districts creating relationships and advocacy with their local government. Look to those where local funds have been applied to health needs of children in schools (Seattle).
- Present the work in a context of improving the health and well being of students.
- Discuss the social/emotional dimension of students as a key ingredient in achieving better WASL performance.
- Identify communities with countywide safety assessment collaboratives (Skagit).

During the last few minutes of the meeting the group turned its attention to discussion of things that seem to be working well.

- Pasco hires mental health providers to come in to the school for the special education students once a week.
- Skagit offers crisis response and intensive case management that is funded by the County, Readiness to Learn and Safe Schools dollars. Students have met Access to Care Standards and the program has reached capacity with fourteen case managers serving 50 individuals.
- The Family Support Center in Pierce has been working in conjunction with Readiness to Learn and the Health Department. With those partners they have given services to the Title XIX children in their seven school districts.

Some other positive practices from the group include:

- Special education funds pay for a full time social worker for those children in Pasco.
- Wrap Around services are funded through Medicaid in Yakima.
- Prevention services for children in Clarkston.
- There is a FAST team for family assistance in Pierce County.
- Also in Pierce County Parent Partners are funded through the local RSN. Their mental health provider hires the partner for each family.
- Some have access to the Tom Dudley Counseling Fund. If the child that is in crisis qualifies for free or reduced lunch they are eligible for help. This fund offers \$1,000 per student for those who qualify.
- Spokane Public Schools is a licensed mental health provider in its own right.

Some other relationships that have worked with non-Medicaid children include:

- Partnering with an early education team and working with the 0–5 age group.

- The Safe Schools program for both PSESD and ESD 101.
- The Express program during the summer.
- Districts and other public entities in Pierce respond rapidly when opportunities materialize, but mental health projects tend to come and go. Sustainability is a major problem.
- Cross training of partners helps to develop partnerships and better services when the all the parties involved are on the same page.
- In Seattle and King County they have found that using a broad 'label' like 'wellness' instead of the usual 'mental health' helps to fight the stigma.
- Vancouver uses district paid mental health staff to support families and students as they move through multiple referral processes and seek services.

The group then discussed a variety of ideas about how to conduct and complete survey questionnaires related to what's working currently, what the promising practices are, and how they are funded. There was agreement that the survey and methods used to complete it in 2003 needed to be improved. Generally the group liked the approach taken by the National Assembly on School Based Health Care. Ideas ranged from developing a short list of questions and sending it out across multiple list serves, to doing more targeted interviews with specific individuals and agencies. The Washington State University Spokane staff will take these ideas back and develop a proposal for the group to consider.

The group will meet next on June 25, 2007. We will meet again at the Comprehensive Health and Education Foundation, just 3 miles south of SeaTac.

Among other things, the agenda will include:

- How RTI Principles might be adapted to the behavioral and mental health needs of students.
- Current status of the literature review and the resource manual.
- Discussion about how to complete interviews with school administrative staff during July and August.
- Formatting of curriculum to be rolled out in September.

**Mental Health and Schools/Response to Intervention
Advisory Board Meeting
C.H.E.F. Center, SeaTac
Wednesday, July 18, 2007**

Minutes

Members Present:

Kelli Hoekstra
Puget Sound ESD

Melissa Robbins
Mental Health Coordinator
Vancouver School District

David Crump
Coordinator
Spokane School District

Tracy Wilson
Assistant Director Special Education
Pasco School District

Ann Allen
Director
ESD 105

Marge Critchlow
Parent
A Common Voice

TJ Cosgrove
Program Manager
Seattle/King County Health Department

Abbie Pack
Assistant Director of Special Education
South Kitsap School District

Judy Gosney
Mental Health Division

Ron Hertel
Program Supervisor OSPI

Teague Griffith
Coordinator
Washington State University Spokane

Roy Harrington
Senior Research Associate
Washington State University Spokane

Members Absent:

Terry Knowles
Education Specialist
Clover Park School District

Kris Rathbun
Program Manager
Clarkston School District

Jack A. Maris
Vice President
Comprehensive Mental Health

Chris Tobey
Youth and Family Services
Skagit Youth and Family Services

Theresa Wright
Director
Youth and Family Services

Karen Traylor
Parent

Lynn Nelson
ESD 113

(Note: July and August are poor times to schedule statewide meetings, especially for K–12 personnel. Absences were a function of family priorities and the need for rest and recuperation).

The minutes from the last meeting were presented again, reviewed, and accepted.

The meeting's agenda is identified in **bold** letters.

1. Response to Intervention

Tonya Middling, OSPI's Learning Improvement Coordinator, shared the Power Point she developed for discussion/presentation of RTI and Behavior with K–12 personnel.

2. Current status of the Literature Review and the Resource Manual (see draft review of literature attached).

The effort was made to confine most of the content which meets an evidence based standard. The committee was generally pleased with the current status of the literature review.

The group suggested that information about EBP's related to Adjustment Disorders, Reactive Attachment, and Trauma be included. It was recommended that adverse childhood experiences study references also be included related to the Adverse Childhood Experiences Study. Sources should also be included related to community and partnership and team building. The "Why Try" and "Beyond Fat City" curricula were also recommended as was the book Crucial Conversations. It was stated that "Preparing for the Drug Free Years" is now listed in the SAMSHA promising approaches site as "Guiding Good Choices." The group also recommended that specific references be found to support/enhance greater understanding in the K 12 system about the need to invite and support parental involvement in schools.

3. Organization/Structure of the Resource Guide to be rolled out in September.

The draft outline for the Manual/Resource Guide is reproduced below. Those items in parentheses reflect observations/comments/recommendations of the group.

I. Executive Summary

- Overview of work process and key findings/recommendations
- (Specific statements must tie improvements in mental health/behavior to achievement.
- The overall issue of well being needs to be discussed in context with improved test scores).

II. What is Mental Health?

- Incidence and prevalence rates.
- The four groups of children.

- Putting the issue in context; special education, 504, BI, other groups.
 - Individual and collective responsibilities of the MENTAL HEALTH and K–12 systems.
 - (Make certain to clarify the differences among a mental health diagnosis, mental health issues, behavior, i.e., differences between a child who may be clinical depressed and one who is withdrawn and sad. Discuss the relationship between the public and private systems; the issue of parity. Clarify that to the degree prevention dollars exist, they reside with DOH).
- III. Approaches taken to bringing Mental Health into proximity with K–12
- What are the promising approaches in Washington?
 - Results of interviews with one third of Districts; what's the level of awareness?
 - (Identify common barriers, including the issue of language, e.g. Case Management, roles).
- IV. Review of Literature
- (Include references to Innovation and Change as related to barriers in this section).
- V. Implications for Practice
- Access and help seeking behavior.
 - Social factors/determinants as a context for engagement with children and parents.
 - Theories of change and stages of change as they relate to learning and learning supports.
 - (Discuss parental involvement and Wraparound in this section, Positive Behavior Supports. Identify other potential partners, such as school based health centers).

4. Discussion/Advice about who to involve in the K–12 Survey.

The intent of the survey is to discover the level of relationship that exists between districts and mental health systems, and those approaches being used to address mental health concerns and behavior. Two significant determinants related to identifying perceived mental health need are poverty and ethnicity. Based on school report card data, all districts have been divided into nine cells reflecting the range from highest poverty to lowest Caucasian ethnicity, to lowest poverty highest Caucasian ethnicity. One third of districts from each cell will be randomly chosen and interviewed using the interview protocol which was reviewed earlier by the committee.

The committee advised that calls to districts be kept as brief as possible, and that they be targeted to personnel who occupy positions in special services, school counseling, school nursing, student services/support, and school superintendents or assistant superintendents. The committee also advised that these calls have to take place in the last three weeks in August or be delayed until October.

Exhibit 2

Regional Support Networks/Publicly Funded Mental Health Agencies

Regional Support Networks of Washington Including Mental Health Agencies



Chelan-Douglas Regional Support Network

Serving Chelan and Douglas Counties
636 North Valley Mall Parkway, Suite 200
East Wenatchee, WA 98802-4875
(509) 886-6318
Toll Free: 1-877-563-3678
Ombuds Services: 1-800-495-5178
24-Hour Crisis Line: 1-800-852-2923
<http://www.cdrsn.org>

Catholic Family and Child Services
23 S. Wenatchee Avenue, Suite #320
Wenatchee, WA 98801-2263
(509) 662-6761
Alternative languages available: Spanish

Columbia Valley Community Health-Behavioral Health Services
701 N. Miller Street
Wenatchee, WA 98801-2086
(509) 662-7195
Alternative languages available: Spanish

Children's Home Society
1014 Walla Walla Avenue
Wenatchee, WA 98801-1523
(509) 663-0034
Alternative languages available: Spanish

Clark County Regional Support Network

Serving Clark County

PO Box 5000

Vancouver, WA 98666-5000

Toll Free: 1-800-410-1910

Ombuds Services: 1-866-666-5070

24-Hour Crisis Line: 1-800-626-8137

<http://www.clark.wa.gov/mental-health>

Catholic Community Services

9300 NE Oak View Drive

Vancouver, WA 98662-5257

(360) 567-2211

Alternative languages available: American Sign Language, French, Russian, and Spanish

Children's Center

415 W. 11th Street

Vancouver, WA 98666-0484

(360) 699-2244

Alternative languages available: Russian and Spanish

Children's Home Society

309 W. 12th Street

Vancouver, WA 98666-0605

(360) 695-1325

Columbia River Mental Health Services

6926 E. Fourth Plain Boulevard

Vancouver, WA 98661-7254

(360) 993-3000

Alternative languages available: American Sign Language, Cambodian, Chinese, French, German, Korean, Laotian, Russian, Spanish, Tagalog, Taiwanese, Thai, and Vietnamese

Family Solutions

1104 Main Street, Suite 500

Vancouver, WA 98660-2972

(360) 695-0115

Alternative languages available: Spanish

Mental Health Northwest

1601 E 4th Plain Blvd, Bldg. A-8

Vancouver, WA 98668-1845

(360) 906-8336

Southwest Washington Medical Center

3400 Main Street

Vancouver, WA 98668-1600

(360) 696-5300

Grays Harbor Regional Support Network

Serving Grays Harbor County
2109 Sumner Avenue
Aberdeen, WA 98520-3699
(360) 532-8665
Toll Free: 1-800-464-7277
Ombuds Services: 1-888-816-6546
24-Hour Crisis Line: 1-800-685-6556
<http://www.ghphss.org/page.aspx?id=99590>

Behavioral Health Resources
575 E. Main Street, Suite C
Elma, WA 98541-9551
(360) 482-5358
Alternative languages available: Spanish

Crisis Clinic
615 8th Street
Hoquiam, WA 98550
(360) 532-4357

Evergreen Counseling Center 205 8th Street
Hoquiam, WA 98550-2507
(360) 532-8629
Alternative languages available: Spanish

Greater Columbia Behavioral Health Regional Support Network

Serving Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Skamania, Walla Walla, Whitman, and Yakima Counties.

101 N. Edison Street

Kennewick, WA 99336-1958

(509) 735-8681

Toll Free: 1-800-795-9296

Ombuds Services: 1-800-257-0660

24-Hour Crisis Lines:

Asotin: 1-888-475-5665

Benton-Franklin: 1-800-783-0544

Columbia: 1-800-734-9927

Garfield: 1-888-475-5665

Kittitas: (509) 925-9861

Klickitat: (509) 733-5801/1-800-572-8122

Skamania: (509) 427-9488

Walla Walla: (509) 522-4278

Whitman: 1-866-871-6385

Yakima: (509) 575-4200/1-800-572-8122

Yakima Children: (509) 576-0934 or 1-800-671-5437

<http://www.gcbh.org>

Benton/Franklin Counties Crisis Response Unit

2635 W. Deschutes Avenue

Kennewick, WA 99336-3004

(509) 783-0500

Alternative languages available: Spanish

Blue Mountain Counseling- Dayton, Columbia County

221 E. Washington Avenue

Dayton WA 99382

(509) 382-1164

Catholic Family and Child Services

5301 Tieton Drive, Suite C

Yakima, WA 98908-3478

(509) 965-7100

Alternative languages available: Spanish

Central Washington Comprehensive Mental Health—Yakima, Yakima County

402 S. Fourth Avenue

Yakima, WA 98907-0959

(509) 575-4084

Alternative languages available: Spanish

Central Washington Comprehensive Mental Health—Ellensburg, Kittitas County
220 W. 4th Avenue
Ellensburg, WA 98926
(509) 925-9861

Central Washington Comprehensive Mental Health—Sunnyside, Yakima County
1319 Saul Road S.
Sunnyside, WA 98944
(509) 837-2089

Central Washington Comprehensive Mental Health—Goldendale, Klickitat County
112 W. Main Street
Goldendale, WA 98620
(509) 773-5801

Central Washington Comprehensive Mental Health—White Salmon, Klickitat
County
251 Rhine Village Drive
White Salmon, WA 98672
(509) 493-3400

Garfield County Human Services
856 W. Main Street
Pomeroy, WA 99347
(509) 843-3791

Inland Counseling Network—Walla Walla, Walla Walla County
225 Woodland Ave
Walla Walla, WA 99362-3002
(509) 525-3278

Inland Counseling Network—Dayton, Columbia County
221 E. Washington Avenue
Dayton, WA 99328
(509) 382-2527

Inland Counseling Network—Dayton, Columbia County
213 W. Clay Street
Dayton, WA 99328
(509) 382-2525

Lourdes Counseling Center
1175 Carondelet Drive
Richland, WA 99352-3396
(509) 943-9104

Alternative languages available: Fijian, Hindi, Meman, Punjabi, Spanish, and Urdu

Lutheran Community Services Northwest
3321 W. Kennewick Avenue, Suite 150
Kennewick, WA 99336-2959
(509) 735-6446

Nueva Esperanza Community Counseling Center—La Clinica
720 W. Court Street, Suite 8
Pasco, WA 99301-4178
(509) 545-6506
Alternative languages available: Spanish and Toisan

Palouse River Counseling Center
340 NE. Maple
Pullman, WA 99163
(509) 334-1133

Rogers Counseling Center
900 7th Street
Clarkston, WA 99403-2058
(509) 758-3341

Senior Solutions
5 W. Alder, Suite #328
Walla Walla, WA 99362
(509) 527-0566

Skamania County Counseling Center
Skamania County Health Services Center
683 SW Rock Creek Drive
Stevenson, WA 98648
(509) 427-9488

Sunderland Family Treatment Services
8656 W. Gage Boulevard, Building C
Kennewick, WA 99336-8120
(509) 736-0704

Walla Walla County Department of Human Services
310 W. Poplar
Walla Walla, WA 99362
(509) 527-3278
Alternative languages available: Spanish

Yakima Valley Farm Workers Clinic Behavioral Health Services—Yakima, Yakima
County
918 E. Mead Avenue
Yakima, WA 98903-3720
(509) 453-1344
Alternative languages available: Spanish

Yakima Valley Farm Workers Clinic Behavioral Health Services—Toppenish,
Yakima County
518 West 1st Avenue
Toppenish, WA 98948-1564
(509) 865-5600

King County Regional Support Network

Serving King County
821 Second Avenue
Seattle, WA 98104
(206) 296-5213
Toll Free: 1-800-790-8049
Ombuds Services: 1-800-790-8049
24-Hour Crisis Line: 1-866-427-4747
<http://www.metrokc.gov/dchs/mhd/>

Asian Counseling and Referral Services

720 8th Avenue S. Suite 200
Seattle, WA 98104-3034
(206) 695-7600
Alternative languages available: Cambodian, Cantonese, French, H'mong, Ilocano, Japanese, Korean, Lao, Mandarin, Mien, Samoan, Tagalog, Thai, Taiwanese, Vietnamese, and Visayan

Children's Hospital and Regional Medical Center Front Desk

4800 Sand Point Way NE
Seattle, WA 98105-0371
(206) 987-2000
Intake (New Patients Only): 206-987-3560
Alternative languages available: American Sign Language

Community House Mental Health

431 Boylston Avenue E.
Seattle, WA 98102-4903
(206) 322-2387
Alternative languages available: Spanish

Community Psychiatric Clinic

4319 Stone Way N.
Seattle, WA 98103-7490
(206) 461-3614
Alternative languages available: Chinese, French, German, Japanese, Spanish, and Tagalog

Consejo Counseling and Referral Services

3808 S. Angeline Street
Seattle, WA 98118-1712
(206) 461-4880
Alternative languages available: Spanish

Downtown Emergency Service Center
507 3rd Avenue
Seattle, WA 98104
(206) 464-1570
Alternative languages available: Spanish

Evergreen Healthcare
2414 SW Andover Street D-120
Seattle, WA 98106
(206) 923-6300 or 1-800-548-0558

Harborview Mental Health Services
325 9th Avenue
Seattle, WA 98104-2499
(206) 731-3411
Alternative languages available: French, Ilocano, Spanish, and Tagalog

Highline/West Seattle Mental Health Center
2600 SW Holden Street
Seattle, WA 98126-3505
(206) 248-8226
Alternative languages available: Interpreters for any language available on request

Sea-Mar Community Health Center
8720 14th Avenue S.
Seattle, WA 98108-4896
(206) 762-3730
Alternative languages available: Spanish

Seattle Children's Home
2142 10th Avenue W.
Seattle, WA 98119-2899
(206) 283-3300
Alternative languages available: American Sign Language, Greek, Spanish, and Vietnamese

Seattle Counseling Service for Sexual Minorities
1216 Pine Street, Suite 300
Seattle, WA 98101
(206) 323-1768
Email: info@seattlecounseling.org

Seattle Mental Health
1600 E. Olive Street
Seattle, WA 98122-2799

Other branches can be located in North Seattle, Bellevue, Redmond, Renton, Kent, Auburn, and Snoqualmie.

(206) 324-0206

Alternative languages available: American Sign Language, French, Gaelic, German, Hebrew, Hindi, Japanese, Mandarin, Russian, Spanish, Tagalog, and Taiwanese

Therapeutic Health Service, Rainier Beach
5802 Rainier Avenue S.
Seattle, WA 98118-2706

(206) 723-1980

Alternative languages available: Amharic, Cambodian, French, Japanese, Luthya, and Swahili

Valley Cities Counseling and Consultation—Auburn, King County
2704 I Street NE
Auburn, WA 98002-2498

(253) 939-4055

Alternative languages available: Czech, French, German, Punjabi, Russian, and Spanish

Valley Cities Counseling and Consultation—Federal Way, King County
33301 1st Way South
Federal Way, WA 98003-6252

(253) 835-9975

Valley Cities Counseling and Consultation—Kent, King County
325 W. Gove Street
Kent, WA 98032-5892

(253) 939-4055

YMCA Mental Health Services
909 Fourth Avenue
Seattle, WA 98104
(206) 382-5340

North Sound Mental Health Administration Regional Support Network

Serving Island, San Juan, Skagit, Snohomish, and Whatcom Counties

117 N. 1st Street, Suite 8

Mount Vernon, WA 98273-2858

1-888-693-7200

Toll Free: 1-800-684-3555

Ombuds Services: 1-888-336-6164

24-Hour Crisis Line: 1-800-584-3578

<http://www.nsrnsn.org>

Associated Provider Network

(Regional Access System for Entire Region)

Bridgeways

1220 75th Street SW

Everett, WA 98203

1-888-693-7200 or (425) 513-8213

Catholic Community Services—Mount Vernon, Skagit County

320 Pacific Place

Mount Vernon, WA 98273

(360) 416-7546

Catholic Community Services—Bellingham, Whatcom County

1133 Railroad Avenue

Bellingham, WA 98225

(360) 676-2164

Compass Health—Everett, Snohomish County

4526 Federal Avenue

Everett, WA 98203-8810

Toll Free: 1-800-457-9303

Alternative languages available: American Sign Language, Arabic, Bosnian, Cambodian, Cantonese, Farsi, French, Japanese, Korean, Mandarin, Romanian, Russian, Spanish, Tagalog, and Ukrainian

Compass Health—Camano Island, Island County

127 NE Camano Drive

Camano Island, WA 99133

(360) 678-5555 or (360) 312-4868

Alternative languages available: Spanish

Compass Health—Friday Harbor, San Juan County

820 Guard Street

Friday Harbor, WA 99133

(360) 378-2669

Alternative languages available: Spanish

Compass Health—Mount Vernon, Skagit County
1100 South 2nd Street
Mount Vernon, WA 99133
(360) 419-3500
Alternative languages available: Spanish

Lake Whatcom Residential and Treatment Center
609 A North Shore Drive
Bellingham WA 98226-4414
(360) 676-6000

Sea Mar Counseling and Social Services—Bellingham, Whatcom County
4455 Cordata Pkwy
Bellingham, WA 98226-8037
(360) 734-5458
Alternative languages available: French and Spanish

Sea Mar Counseling and Social Services—Everett, Snohomish County
8625 Evergreen Way, Suite #255
Everett, WA 98208-2620
(425) 347-5415
Alternative languages available: French and Spanish

Sea Mar Counseling and Social Services—Mount Vernon, Skagit County
1400 N. LaVenture Road
Mount Vernon, WA 98273-2766
(360) 428-8912
Alternative languages available: French and Spanish

Whatcom Counseling and Psychiatric Clinic
3645 E. McLeod Road
Bellingham, WA 98226-8799
(360) 676-2220 or 1-888-311-0120

Peninsula Regional Support

Serving Clallam, Jefferson, and Kitsap Counties

614 Division Street, MS 23

Port Orchard, WA 98366-4676

Network (360) 337-4886

Toll Free: 1-800-525-5637

Ombuds Services: 1-800-531-0508

Toll Free: 1-800-531-0508

24-Hour Crisis Lines:

Kitsap County: (360) 373-3425/(800) 843-4793

East Jefferson County: (360) 385-0321/(800) 659-0321

East Clallam County: (360) 452-4500

West Jefferson County: (360) 374-5011

West Clallam County: (360) 374-5011

(Non-Business hours): (360) 374-6271

Jefferson Mental Health Services

884 West Park Avenue

Port Townsend, WA 98368-0565

(360) 385-0321

Kitsap Mental Health Services

5455 Almira Drive

Bremerton, WA 98311-8331

(360) 405-4010

Alternative languages available: Japanese, Spanish, and Tagalog

Peninsula Community Mental Health Center

118 East 8th Street

Port Angeles, WA 98362-6129

(360) 457-0431

West End Outreach Services

530 Bogachiel Way

Forks, WA 98331-9120

(360) 374-5011

Alternative languages available: Spanish

Pierce County Regional Support Network

Serving Pierce County

3580 Pacific Avenue

Tacoma, WA 98418-7915

(253) 798-7202

Toll Free: 1-800-531-0508

Ombuds Services: 1-800-531-0508

24-Hour Crisis Line: 1-800-576-7764

<http://www.co.pierce.wa.us/pc/services/health/mental/services.htm>

Asian Counseling Services

4301 South Pine Street, Suite 405

Tacoma, WA 98409

(253) 471-0141

Alternative languages available: Many Asian Languages spoken

Catholic Community Services

5410 N. 44th Street

Tacoma, WA 98407-3799

(253) 759-9544

Alternative languages available: Cambodian, French, German, Korean, Lakota, Navajo, Nigerian, Romanian, Spanish, and Swedish

Comprehensive Mental Health (Tacoma/Peninsula Area)

514 S. 13th Street

Tacoma, WA 98402 (Adults/Older Adults)

(253) 396-5000

1201 S. Proctor Street, Suite 1

Tacoma, WA 98405-2095 (Children/Families)

(253) 396-5800

Alternative languages available: American Sign Language, Cantonese, Farsi, German, Greek, Hindi, Italian, Mandarin, Punjabi, Russian, Spanish, Tagalog, Ukrainian, and Vietnamese

Crisis Intervention Teams:

Tacoma/Peninsula Area: (253) 396-5089

Lakewood/Southwest Pierce County Area: (253) 584-8933

Puyallup/East Pierce County Area: (253) 584-8125 or 1-888-445-8125

Good Samaritan Community Health Care

Puyallup/East Pierce County

325 E. Pioneer

Puyallup, WA 98372-3265

(253) 445-8120

Alternative languages available: Cambodian, German, Korean, Spanish, Thai, and Vietnamese

Greater Lakes Mental Healthcare - Lakewood/Southwest Pierce County
9330 59th Avenue SW
Lakewood, WA 98499-6600
(253) 581-7020
Alternative languages available: American Sign Language, Korean, and Spanish

Kwawatchee Counseling Center of the Puyallup Tribal Health Authority
2209 E. 32nd Street
Tacoma, WA 98404-4997
(253) 593-0247
Mobile Outreach Crisis Services
(253) 798-2709
Crisis Triage
3580 Pacific Avenue
Tacoma, WA 98418-7915
(253) 798-4357

Sea Mar Counseling and Social Services
1112 S. Cushman Avenue
Tacoma, WA 98405-3631
(253) 396-1634
Alternative languages available: Spanish

Southwest Regional Support Network

Serving Cowlitz County

1952 9th Avenue

Longview, WA 98632-4045

1-800-803-8833

Toll Free: 1-800-347-6092

Public Phone: (360) 501-1201

Ombuds Services: (360) 414-0237

24-Hour Crisis Line: 1-800-803-8833

Southwest RSN Web site: <http://www.dshs.wa.gov/mentalhealth/southwest.shtml>

Center for Behavioral Solutions

600 Broadway

Longview, WA 98632-3256

(360) 414-2280

Alternative languages available: Spanish

Lower Columbia Mental Health Center

921 14th Avenue

Longview, WA 98632-2316

(360) 423-0203

Alternative languages available: Filipino, German, Russian, and Spanish

Saint John Medical Center

600 Broadway

Longview, WA 98632-3256

(360) 414-2029

Alternative languages available: Spanish

SL Start

214 N Pacific Avenue

Kelso, 98626

(360) 577-5717

Toutle River Boys Ranch

PO Box 2052

Longview, WA 98632-3256

(360) 423-6741

Spokane County Regional Support Network

Serving Spokane County
312 West 8th Avenue, Fourth Floor
Spokane WA 99204-2506
(509) 477-5722
Toll Free: 1-800-273-5864
Ombuds Services: 1-866-814-3409
24-Hour Crisis Line: 1-877-678-4428
<http://www.spokanecounty.org/mentalhealth>

Catholic Family Services
1023 W. Riverside Avenue
Spokane, WA 99210-1453
(509) 358-4269

Children's Home Society of Washington
2323 N. Discovery Place
Spokane Valley, WA 99216-1566
(509) 747-4174

Family Service Spokane
7 S. Howard Street, Suite 321
Spokane, WA 99201-3816
(509) 838-4128

Grief Counseling Services
1016 N. Superior Street
Spokane, WA 99202-2059
(509) 238-6182
Alternative languages available: Spanish

Hope Partners/REM Associates
1117 West First Avenue
Spokane, WA 99201
(509) 835-3599

Lutheran Social Services NW
7 S. Howard Street, Suite #200
Spokane, WA 99201-3823
(509) 747-8224
Alternative languages available: American Sign Language, French, and Spanish

Spokane Mental Health
107 S. Division Street
Spokane, WA 99202-1586
(509) 838-4651

Alternative languages available: American Sign Language, French, German,
Latin, Spanish, Tagalog, and Vietnamese

Spokane County Supportive Living Program
315 W. Mission Avenue, Suite #26
Spokane, WA 99201-2327
(509) 477-4386

Alternative languages available: Spanish

The N.A.T.I.V.E. Project
1803 W. Maxwell Avenue
Spokane, WA 99201-2831
(509) 325-5502

Thurston-Mason Regional Support Network

Serving Mason and Thurston Counties

412 Lilly Road NE

Olympia, WA 98506-5132

(360) 786-5585

Toll Free: 1-800-624-1234

Ombuds Services: 1-800-624-1234

24-Hour Crisis Line: 1-800-627-2211

Behavioral Health Resources

3857 Martin Way E

Olympia, WA 98506

(360) 704-7170 or 1-800-825-4820

Alternative languages available: American Sign Language, Cantonese, French, German, Mandarin, Russian, Spanish, and Vietnamese

Behavioral Health Resources

6340 Capitol Boulevard S.

Olympia, WA 98507-0677

(360) 754-7576

Alternative languages available: American Sign Language, Cantonese, French, German, Mandarin, Russian, Spanish, and Vietnamese

Timberlands Regional Support Network

Serving Lewis, Pacific, and Wahkiakum Counties

PO Box 217

Cathlamet, WA 98612-0217

(360) 795-3118

Toll Free: 1-800-392-6298

Public Phone: (360) 795-3118

Ombuds Services: 1-888-662-8776

24-Hour Crisis Lines:

Lewis County: 1-800-559-6696

Pacific County: 1-800-884-2298

Wahkiakum County: 1-800-635-5989

Cascade Mental Health Care

135 W. Main

Chehalis, WA 98532-0378

(360) 748-6696

Toll Free: 1-800-559-6696

2428 Reynolds Avenue

Centralia, WA 98531

(360) 330-9044/1-800-559-6696

(Child and Adolescent Program)

Wahkiakum County Mental Health Services

42 Elochoman Valley Road

Cathlamet, WA 98612-9602

(360) 795-8630/1-800-635-5989

Willapa Counseling Center

1107 North Pacific Hwy

Long Beach, WA 98631

(360) 642-3787/1-800-884-2298

819 Alder

South Bend, WA 98586

(360) 895-9426/1-800-884-2298

Exhibit 3

Educational Service District Map of Washington State

ESD 101

4202 S. Regal
 Spokane, 99223-7764
 (509) 789-3800
<http://www.esd101.net>

ESD 105

33 S. 2nd Ave.
 Yakima, 98902-3486
 (509) 575-2885
<http://www.esd.105.wednet.edu>

ESD 114 - Olympic

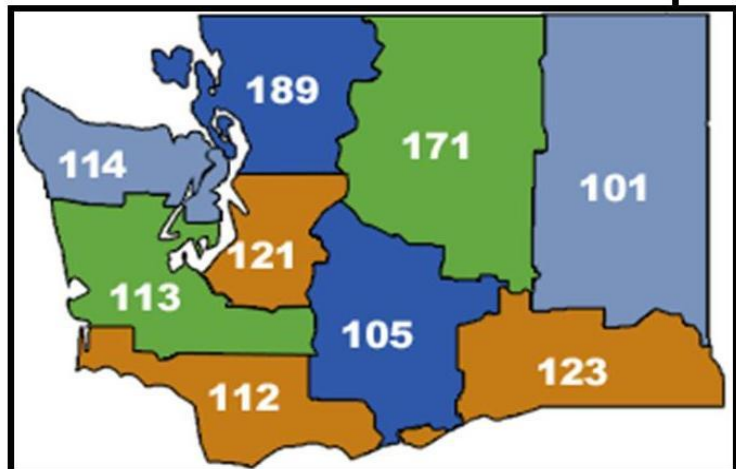
105 National Ave. N.
 Bremerton, 98312
 (360) 479-0993
<http://www.oesd.wednet.edu>

ESD 112

2500 N.E. 65th Ave.
 Vancouver, 98661-6812
 (360) 750-7500
<http://www.esd112.org>

ESD 113

601 McPhee Rd. S.W.
 Olympia, 98502-5080
 (360) 464-6700
<http://www.esd113.k12.wa.us>

**ESD 121 - Puget Sound**

800 Oakesdale Ave. SW
 Renton, 98055
 (425) 917-7600
 (800) 664-4549
<http://www.psesd.org>

ESD 123

3918 W. Court St.
 Pasco, 99301
 (509) 547-8441
<http://www.esd123.org>

ESD 171 - North Central

430 Old Station Road
 PO Box 1847
 Wenatchee, 98801
 (509) 665-2610
<http://www.ncesd.org>

ESD 189 - Northwest

1601 R Avenue
 Anacortes, 98221
 (360) 299-4000
<http://www.esd189.org>

Exhibit 4

Federal Poverty Guidelines

Income levels are effective April 1, 2007 through March 31, 2007. If your monthly family income is close to the amounts on the chart, your kids may qualify for free or low-cost health insurance. Even if your income is above these amounts, we still encourage you to call 1-877-KIDS-NOW or download the Healthy Kids Now! application.

This graphic reflects the Federal Poverty Index at 200 percent.

Number of People in Family (includes parents and children)	Medicaid Free Health Insurance (approx. income per month)	SCHIP Low-cost Health Insurance (approx. income per month)
1	Up to \$1,702	\$1,703 to \$2,128
2	Up to \$2,282	\$2,283 to \$2,853
3	Up to \$2,862	\$2,863 to \$3,578
4	Up to \$3,442	\$3,443 to \$4,303
5	Up to \$4,022	\$4,023 to \$5,028
More	Add \$580 for each additional family member	Add \$725 for each additional family member

Exhibit 5

Access to Care Standards

Access to Care Standards—January 1, 2006
Eligibility Requirements for Authorization of Services for Medicaid Children and Youth

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:

The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.

The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.

The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.

The individual is expected to benefit from the intervention.

The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

*** = Descriptive Only**

	Level One—Brief Intervention	Level Two—Community Support
Goal and Period of Authorization*	<p>Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment OR long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery.</p> <p>The period of authorization may be up to six months of care OR may be up to twelve months of care when an individual is receiving long term, low intensity treatment.</p>	<p>Longer term treatment is necessary to achieve or maintain stability OR requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services.</p> <p>The period of authorization may be up to six months of care OR may be up to twelve months of care as determined by medical necessity and treatment goal(s).</p>

	Level One—Brief Intervention	Level Two—Community Support
<p>Functional Impairment.</p> <p>Must be the result of an emotional disorder or a mental illness.</p>	<p>Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND—</p> <p><u>Impairment is evidenced by a Children’s Global Assessment Scale (CGAS) Score of 60 or below.</u> (Children under 6 are exempted from CGAS).</p> <p>Domains include: Health and Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications.</p> <p>Cultural Factors: Home and Family Life Safety and Stability. Work, school, daycare, pre-school or other daily activities Ability to use community resources to fulfill needs.</p>	<p>Must demonstrate severe and persistent functional impairment in at least <u>one</u> life domain requiring assistance in order to meet identified need AND—</p> <p><u>Impairment is evidenced by a Children’s Global Assessment Scale (CGAS) Score of 50 or below.</u> (Children under 6 are exempted from CGAS).</p> <p>Domains include: Health and Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications.</p> <p>Cultural Factors: Home and Family Life Safety and Stability. Work, school, daycare, pre-school or other daily activities Ability to use community resources to fulfill need.</p>
<p>Covered Diagnosis</p>	<p>Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children’s mental health specialist is required.</p> <p>Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)</p>	<p>Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children’s mental health specialist is required.</p> <p>Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders).</p>

	Level One—Brief Intervention	Level Two—Community Support
Supports and Environment*	Natural support network is experiencing challenges, i.e., multiple stressors in the home; family or caregivers lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more child serving systems requiring coordination.	Significant stressors are present in home environment, i.e., change in custodial adult; out of home placement; abuse or history of abuse; and situation exceeds the resources of natural support system. May be involvement with one or more child serving system requiring coordination.
EPSDT Plan	Level One Services are defined as short-term mental health services for children/families with less severe need. An ISP should be developed and appropriate referrals made. Children eligible for Level One EPSDT services in the 1992 EPSDT plan are included here.	Children eligible for Level Two EPSDT services in the 1992 EPSDT plan are defined as needing longer term, multi-agency services designed to meet the complex needs of an individual child and family. Level Two is authorized for children with multi-system needs or for children who are high utilizers of services from multiple agencies. EPSDT children authorized for this level will be referred to and may require an individual treatment team in accordance with the EPSDT Plan.
Minimum Modality Set	<p>Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment:</p> <p>Brief Intervention Treatment Medication Management Psycho-education Group Treatment Family Supports</p> <p>The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.</p>	<p>Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One,</u> individuals may be referred for the following treatment:</p> <p>Individual Treatment Medication Monitoring</p> <p>The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.</p>

	Level One—Brief Intervention	Level Two—Community Support
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Children and Youth—January 1, 2006

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Children and Youth are further defined in the Access to Care Standards.

Please note: The following covered diagnoses must be considered for coverage.

DSM— IV— TR Code	DSM—IV—TR Description	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
312.81	Conduct Disorder, Childhood-Onset Type	B
312.82	Conduct Disorder, Adolescent-Onset Type	B
312.89	Conduct Disorder, Unspecified Onset	B
313.81	Oppositional Defiant Disorder	B
312.9	Disruptive Behavior Disorder NOS	B
	OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE	
309.21	Separation Anxiety Disorder	A
313.23	Selective Mutism	B
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	B

307.3	Stereotypical Movement Disorder	B
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to (Indicate the General Medical Condition) With Delusions	A
293.82	Psychotic Disorder Due to (Indicate the General Medical Condition) With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS	
	DEPRESSIVE DISORDERS	
296.22	Major Depressive Disorder Single Episode, Moderate	A
DSM— IV—TR Code	DSM— IV—TR Description	A = Covered B = Covered with Additional Criteria
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A

296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	A
311	Depressive Disorder NOS	A
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A

296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
DSM— IV— TR Code	DSM— IV—TR Description	A = Covered B = Covered with Additional Criteria
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	A
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	A
300.21	Panic Disorder With Agoraphobia	A
300.22	Agoraphobia Without History of Panic Disorder	A
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	A
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	A
300.00	Anxiety Disorder NOS	A
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological	B

	Signs and Symptoms	
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
DSM— IV— TR Code	DSM— IV—TR Description	A = Covered B = Covered with Additional Criteria
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a B diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

[Please note: CGAS is generally not considered valid for children under the age of six. The DC03 may be substituted. Children under six are exempted from Axis V scoring. Very young children in need of mental health care may not readily fit diagnostic criteria. The degree of functional impairment related to the symptoms of an emotional disorder or mental illness should determine eligibility. Functional impairment for very young children is described in the last bullet].

- High-risk Behavior demonstrated during the previous 90 days—aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness.
- At-risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs.
- Two or more hospital admissions due to a mental health diagnosis during the previous two years.
- Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year or is currently being discharged from a psychiatric hospitalization.
- Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment).

Child is under six years of age and there is a severe emotional abnormality in the child's overall functioning as indicated by one of the following:

1. Atypical behavioral patterns as a result of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers).
2. Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g., inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers).

Exhibit 6

Wraparound Principles

Ten Principles of the Wraparound Process

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October 1, 2004

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A Product of the National Wraparound Initiative—October 1, 2004 version.

Introduction

The philosophical principles of Wraparound have long provided the basis for understanding this innovative and widely-practiced service delivery model. This value base for working in collaboration and partnership with families extends from Wraparound's roots in programs such as Kaleidoscope in Chicago, the Alaska Youth Initiative, and Project Wraparound in Vermont. In 1999, a monograph on Wraparound was published. That presented ten core elements of Wraparound, as well as ten practice principles, from the perspective of Wraparound process innovators.¹ These elements and practice principles spanned activity at the team, organization, and system levels; for example, some elements were intended to guide direct work that happens with the youth, family and hands-on support people (team level). Some elements referred to work by the agency or organization housing the Wraparound initiative (program level); and some guided the funding and community context around the Wraparound activities (system level). For many, these original elements and principles became the best means available for understanding the Wraparound process and provided an important basis for initial efforts at measuring fidelity.

Many have expressed a need to move beyond a value base for Wraparound in order to facilitate program development and replicate positive outcomes. However, Wraparound's philosophical principles will always remain the starting point for understanding the model. The current document attempts to make the Wraparound principles even more useful as a framework and guide for high-quality practice for youth and families. It describes Wraparound's principles exclusively at the youth/family/team level. In doing so, we hope the organizational and system supports necessary to achieve high-quality Wraparound practice² will always be grounded in the fundamental need to achieve the Wraparound principles for families and their teams. By revisiting the original elements of Wraparound, we also capitalized on an opportunity to break complex principles (e.g., individualized and strengths-based) into independent ones, and make sure the principles aligned with other aspects of the effort to operationalize the Wraparound process.

The current document is the result of a small team of Wraparound innovators, family advocates, and researchers working together over several months. This team revised the original elements and practice principles and provided them to a much larger national group of family members, program administrators, trainers, and researchers familiar with Wraparound. Through several stages of work, these individuals voted on the principles presented, provided feedback on phraseology, and participated in a consensus-building process.³

¹Goldman, S.K. (1999). The Conceptual Framework for Wraparound. In Burns, B. J. and Goldman, K. (Eds.), *Systems of care: Promising practices in children's mental health*, 1998 series, Vol. IV: Promising practices in Wraparound for children with severe emotional disorders and their families. Washington DC: Center for Effective Collaboration and Practice.

²Another component of the National Wraparound initiative, originally described in detail in Walker, J.S., Koroloff, N., and Schutte, K. (2003). *Implementing high-quality collaborative individualized service/support planning: Necessary conditions*. Portland, OR: Research and Training Center on Family Support and Children's Mental Health.

³Description of the Delphi process used can be found on the National Wraparound Initiative's web page at www.rtc.pdx.edu/nwi/NWIMethod.htm.

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Though far from complete, consensus on the principles as presented here was strong. Nonetheless, you will see as you read descriptions of these ten principles that there are several key areas where the complexity of Wraparound itself hindered realization of a clear consensus among our advisory group. Commentary provided with each principle highlights such tensions and goes into much greater depth about the intentions and implications of each principle.

Considered along with its accompanying materials, we hope that this document helps achieve the main goal expressed by members of the National Wraparound Initiative at its outset: To provide clarity on the specific characteristics of the Wraparound process model for the sake of communities, programs, and families. Just as important, we hope that this document is viewed as a work in progress, and that it remains a living document that can be updated as needed based on feedback from an even broader audience of reviewers.

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Ten Principles of the Wraparound Process

- 1. Family voice and choice.** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the Wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

The Wraparound process recognizes the importance of long-term connections between people, particularly the bonds between family members. The principle of family voice and choice in Wraparound stems from this recognition and acknowledges that the people who have a long-term, ongoing relationship with a child or youth have a unique stake in and commitment to the Wraparound process and its outcomes. This principle further recognizes that a young person who is receiving Wraparound also has a unique stake in the process and its outcomes. The principle of family voice and choice affirms that these are the people who should have the greatest influence over the Wraparound process as it unfolds.

This principle also recognizes that the likelihood of successful outcomes and youth/child and family ownership of the Wraparound plan are increased when the Wraparound process reflects family members' priorities and perspectives. The principle thus explicitly calls for family voice—the provision of opportunities for family members to fully explore and express their perspectives during Wraparound activities—and family choice—the structuring of decision making such that family members can select, from among various options, the one(s) that are most consistent with their own perceptions of how things are, how things should be, and what needs to happen to help the family achieve its vision of well-being. Wraparound is a collaborative process (principle 3); however within that collaboration, family members' perspectives must be the most influential.

The principle of voice and choice explicitly recognizes that the perspectives of family members are not likely to have sufficient impact during Wraparound unless intentional activity occurs to ensure their voice and choice drives the process. Families of children with emotional and behavioral disorders are often stigmatized and blamed for their children's difficulties. This and other factors—including possible differences in social and educational status between family members and professionals, and the idea of professionals as experts whose role is to fix the family—can lead teams to discount, rather than prioritize, family members' perspectives during group discussions and decision making. These same factors also decrease the probability that youth perspectives will have impact in groups when adults and professionals are present. Furthermore, prior experiences of stigma and shame can leave family members reluctant to express their perspectives at all. Putting the principle of youth and family voice and choice into action thus requires intentional activity that supports family members as they explore their perspectives and as they express their perspectives during the various activities of Wraparound. Further intentional activity must take place

to ensure that this perspective has sufficient impact within the collaborative process, so that it exerts primary influence during decision making. Team procedures, interactions, and products—including the Wraparound plan—should provide evidence that the team is indeed engaging in intentional activity to prioritize the family perspectives.

While the principle speaks of family voice and choice, the Wraparound process recognizes that the families who participate in Wraparound, like American families generally, come in many forms. In many families, it is the biological parents who are the primary caregivers and who have the deepest and most enduring commitment to a youth or child. In other families, this role is filled by adoptive parents, step-parents, extended family members, or even non-family caregivers. In many cases, there will not be a single, unified family perspective expressed during the various activities of the Wraparound process. Disagreements can occur between adult family members/ caregivers or between parents/caregivers and extended family. What is more, as a young person matures and becomes more independent, it becomes necessary to balance the collaboration in ways that allow the youth to have growing influence within the Wraparound process. Wraparound is intended to be inclusive and to manage disagreement by facilitating collaboration and creativity; however, throughout the process, the goal is always to prioritize the influence of the people who have the deepest and most persistent connection to the young person and commitment to his or her well-being.

Special attention to the balancing of influence and perspectives within Wraparound is also necessary when legal considerations restrict the extent to which family members are free to make choices. This is the case, for example, when a youth is on probation, or when a child is in protective custody. In these instances, an adult acting for the agency may take on provider and/or decision making responsibilities vis-à-vis the child, and may exercise considerable influence within Wraparound. In conducting our review of opinions of Wraparound experts about the principles, this has been one of several points of contention; specifically, how best to balance the priorities of youth and family against those of these individuals. Regardless, there is strong consensus in the field that the principle of family voice and choice is a constant reminder that the Wraparound process must place emphasis on the perspectives of the people who will still be connected to the youth after agency involvement has ended.

2. Team based. The Wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.

Wraparound is a collaborative process (see principle 3), undertaken by a team. The Wraparound team should be composed of people who have a strong commitment to the family's well-being. In accordance with principle 1, choices about who is invited to join the team should be driven by family members' perspectives.

At times, family members' choices about team membership may be shaped or limited by practical or legal considerations. For example, one or more family members may be reluctant to invite a particular person—e.g., a teacher, a therapist, a probation officer, or a non-custodial ex-spouse—to join the team. At the same time, not inviting that person may mean that the team will not have access to resources and/or interpersonal support that would otherwise be available. Not inviting a particular person to join the team can also mean that the activities or support that he or she offers will not be coordinated with the team's efforts. It can also mean that the family loses the opportunity to have the team influence that person so that he or she becomes better able to act supportively. If that person is a professional, the team may also lose the opportunity to access services or funds that are available through that person's organization or agency. Not inviting a particular professional to join the team may also bring undesired consequences, for example, if participation of the probation officer on the Wraparound team is required as a condition of probation. Family members should be provided with support for making informed decisions about whom they invite to join the team, as well as support for dealing with any conflicts or negative emotions that may arise from working with such team members. Or, when relevant and possible, the family should be supported to explore options such as inviting a different representative from an agency or organization. Ultimately, the family may also choose not to participate in Wraparound.

When a state agency has legal custody of a child or youth, the caregiver in the permanency setting and/or another person designated by that agency may have a great deal of influence over who should be on the team; however, in accordance with principle 1, efforts should be made to include participation of family members and others who have a long-term commitment to the young person and who will remain connected to him or her after formal agency involvement has ended.

3. Natural supports. The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The Wraparound plan reflects activities and interventions that draw on sources of natural support.

This principle recognizes the central importance of the support that a youth/child, parents/caregivers, and other family members receive naturally, i.e., from the individuals and organizations whose connection to the family is independent of the formal service system and its resources. These sources of natural support are sustainable and thus most likely to be available for the youth/child and family after Wraparound and other formal services have ended. People who represent sources of natural support often have a high degree of importance and influence within family members' lives. These relationships bring value to the Wraparound process by broadening the diversity of support, knowledge, skills, perspectives, and strategies available to the team. Such individuals and organizations also may be able to provide certain types of support that more formal or professional providers find hard to provide.

The primary source of natural support is the family's network of interpersonal relationships, which includes friends, extended family, neighbors, co-workers, church members, and so on. Natural support is also available to the family through community institutions, organizations, and associations such as churches, clubs, libraries, or sports leagues. Professionals and paraprofessionals who interact with the family primarily offer paid support; however, they can also be connected to family members through caring relationships that exceed the boundaries and expectations of their formal roles. When they act in this way, professionals and paraprofessionals too can become sources of natural support.

Practical experience with Wraparound has shown that formal service providers often have great difficulty accessing or engaging potential team members from the family's community and informal support networks. Thus, there is a tendency that these important relationships will be underrepresented on Wraparound teams. This principle emphasizes the need for the team to act intentionally to encourage the full participation of team members representing sources of natural support.

4. Collaboration. Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single Wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

Wraparound is a collaborative activity—team members must reach collective agreement on numerous decisions throughout the Wraparound process. For example, the team must reach decisions about what goals to pursue, what sorts of strategies to use to reach the goals, and how to evaluate whether or not progress is actually being made in reaching the goals. The principle of collaboration recognizes that the team is more likely to accomplish its work when members approach decisions in an open-minded manner, prepared to listen to and be influenced by other team members' ideas and opinions. Team members must also be willing to provide their own perspectives, and the whole team will need to work to ensure that each member has opportunities to provide input and feels safe in doing so. As they work to reach agreement, team members will need to remain focused on the team's overarching goals and how best to achieve these goals in a manner that reflects all of the principles of Wraparound.

The principle of collaboration emphasizes that each team member must be committed to the team, the team's goals, and the Wraparound plan. For professional team members, this means that the work they do with family members is governed by the goals in the plan and the decisions reached by the team. Similarly, the use of resources available to the team—including those controlled by individual professionals on the team—should be governed by team decisions and team goals.

This principle recognizes that there are certain constraints that operate on team decision making, and that collaboration must operate within these boundaries. In particular, legal mandates or other requirements often constrain decisions. Team members must be willing to work creatively and flexibly to find ways to satisfy these mandates and requirements while also working towards team goals.

Finally, it should be noted that, as for principles 1 (family voice and choice) and 2 (team-based), defining Wraparound's principle of collaboration raises legitimate concern about how best to strike a balance between Wraparound being youth- and family-driven as well as team-driven. This issue is difficult to resolve completely, because it is clear that Wraparound's strengths as a planning and implementation process derive from being team-based and collaborative while also prioritizing the perspectives of family members and natural supports who will provide support to the youth and family over the long run. Such tension can only be resolved on an individual family and team basis, and is best accomplished when team members, providers, and community members are well supported to fully implement Wraparound in keeping with all its principles.

5. Community-based. The Wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

This principle recognizes that families and young people who receive Wraparound, like all people, should have the opportunity to participate fully in family and community life. This implies that the team will strive to implement service and support strategies that are accessible to the family and that are located within the community where the family chooses to live. Teams will also work to ensure that family members receiving Wraparound have greatest possible access to the range of activities and environments that are available to other families, children, and youth within their communities, and that support positive functioning and development.

6. Culturally competent. The Wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

The perspectives people express in Wraparound—as well as the manner in which they express their perspectives—are importantly shaped by their culture and identity. In order to collaborate successfully, team members must be able to interact in ways that demonstrate respect for diversity in expression, opinion, and preference, even as they work to come together to reach decisions. This principle emphasizes that respect toward the family in this regard is particularly crucial, so that the principle of family voice and choice can be realized in the Wraparound process.

This principle also recognizes that a family's traditions, values, and heritage are sources of great strength. Family relationships with people and organizations with whom they share a cultural identity can be essential sources of support and resources; what is more, these connections are often natural in that they are likely to endure as sources of strength and support after formal services have ended. Such individuals and organizations also may be better able to provide types of support difficult to provide through more formal or professional relationships. Thus, this principle also emphasizes the importance of embracing these individuals and organizations, and nurturing and strengthening these connections and resources so as to help the team achieve its goals, and help the family sustain positive momentum after formal Wraparound has ended.

This principle further implies that the team will strive to ensure that the service and support strategies that are included in the Wraparound plan also build on and demonstrate respect for family members' beliefs, values, culture, and identity. The principle requires that team members are vigilant about ensuring that culturally competent services and supports extend beyond Wraparound team meetings.

7. Individualized. To achieve the goals laid out in the Wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

This principle emphasizes that, when Wraparound is undertaken in a manner consistent with all of the principles, the resulting plan will be uniquely tailored to fit the family. The principle of family voice and choice lays the foundation for individualization. That principle requires that Wraparound must be based in the family's perspective about how things are for them, how things should be, and what needs to happen to achieve the latter. Practical experience with Wraparound has shown that when families are able to fully express their perspectives, it quickly becomes clear that only a portion of the help and support required is available through existing formal services. Wraparound teams are thus challenged to create strategies for providing help and support that can be delivered outside the boundaries of the traditional service environment. Moreover, the Wraparound plan must be designed to build on the particular strengths of family members, and on the assets and resources of their community and culture. Individualization necessarily results as team members collaboratively craft a plan that capitalizes on their collective strengths, creativity, and knowledge of possible strategies and available resources.

8. Strengths based. The Wraparound process and the Wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

The Wraparound process is strengths based in that the team takes time to recognize and validate the skills, knowledge, insight, and strategies that each team member has used to meet the challenges they have encountered in life.

The Wraparound plan is constructed in such a way that the strategies included in the plan capitalize on and enhance the strengths of the people who participate in carrying out the plan. This principle also implies that interactions between team members will demonstrate mutual respect and appreciation for the value each person brings to the team.

The commitment to a strengths orientation is particularly pronounced with regard to the child or youth and family. Wraparound is intended to achieve outcomes not through a focus on eliminating family members' deficits but rather through efforts to utilize and increase their assets. Wraparound thus seeks to validate, build on, and expand family members' psychological assets (such as positive self-regard, self-efficacy, hope, optimism, and clarity of values, purpose, and identity), their interpersonal assets (such as social competence and social connectedness), and their expertise, skill, and knowledge.

9. Persistence. Despite challenges, the team persists in working toward the goals included in the Wraparound plan until the team reaches agreement that a formal Wraparound process is no longer required.

This principle emphasizes that the team's commitment to achieving its goals persists regardless of the child's behavior or placement setting, the family's circumstances, or the availability of services in the community. This principle includes the idea that undesired behavior, events, or outcomes are not seen as evidence of child or family failure and are not seen as a reason to eject the family from Wraparound. Instead, adverse events or outcomes are interpreted as indicating a need to revise the Wraparound plan so that it more successfully promotes the positive outcomes associated with the goals. This principle also includes the idea that the team is committed to providing the supports and services that are necessary for success, and will not terminate Wraparound because available services are deemed insufficient. Instead, the team is committed to creating and implementing a plan that reflects the Wraparound principles, even in the face of limited system capacity.

It is worth noting that the principle of persistence is a notable revision from unconditional care. This revision reflects feedback from Wraparound experts, including family members and advocates, that for communities using the Wraparound process, describing care as unconditional may be unrealistic and possibly yield disappointment on the part of youth and family members when a service system or community cannot meet their own definition of unconditional. Resolving the semantic issues around unconditional care has been one of the challenges of defining the philosophical base of Wraparound. Nonetheless, it should be stressed that the principle of persistence continues to emphasize the notion that teams work until a formal Wraparound process is no longer needed, and that Wraparound programs adopt and embrace "no eject, no reject" policies for their work with families.

10. Outcome based. The team ties the goals and strategies of the Wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

This principle emphasizes that the Wraparound team is accountable—to the family and to all team members; to the individuals, organizations and agencies that participate in Wraparound; and, ultimately, to the public—for achieving the goals laid out in the plan. Determining outcomes and tracking progress toward outcomes should be an active part of Wraparound team functioning. Outcome monitoring allows the team to regularly assess the effectiveness of plan as a whole, as well as the strategies included within the plan, and to determine when the plan needs revision. Tracking progress also helps the team maintain hope, cohesiveness, and efficacy. Tracking progress and outcomes also helps the family know that things are changing. Finally, team-level outcome monitoring aids the program and community to demonstrate success as part of their overall evaluation plan, which may be important to gaining support and resources for Wraparound teams throughout the community.

A Product of the National Wraparound Initiative—October 1, 2004 version

Made available by the Research and Training Center at Portland State University's School of Social Work.

Exhibit 7

Activities That Promote Promising Practices (2003 Version)

EXAMPLES OF ACTIVITIES THAT PROMOTE PROMISING PRACTICES

House Bill 1784 – 2003 Washington State Legislative Session

I. Practice: Family and community engagement, together with school efforts, promotes a school climate that is safe, supportive and respectful. It provides an array of mental health services and educational opportunities to meet the mental health and academic needs of the student and his/her family

Evidence: (Information Dissemination)	Informational Materials/Documents	Public Meetings	Environment/Cult ure	Culturally/Linguistica lly Competent Staff	List of Community Partners	Interagency Agreement/ Memorandum of Understanding (MOU)
Indicator 1: <i>Evidence of outreach to families with mental health needs</i>	Parent Handbook <ul style="list-style-type: none"> • Program description • Program expectations • Team process training Program flyers sent to all district families via mail, e-mail, student delivery, and posted in obvious public view places Telephone calls/phone tree, E-mail listserv Newsletter distribution Special attention paid to isolated families/students (e.g., homelessness, extreme poverty, etc.) Informational videos for parents to check out	Community wide training Public notifications of meetings are made/invitations are sent out. Meeting minutes provided through various sources including newsletters and direct mailing/ e-mailing Parenting classes with meals that are provided by service clubs	Treatment occurs in centers that are culturally relevant. The culture of the student and family is recognized, respected and upheld Wraparound planning is used that incorporates a wide array of community members representative of the cultural makeup of the community	Multi-lingual brochures Staff culture and family culture match Bilingual/bicultural staff are available for consultation Minority mental health specialists are used to address issues culturally appropriately Interpreters available Utilize university-based multicultural program resources for consultation	Public schools including Special Education and Educational Services Districts and Community Mental Health Agencies, Crisis Response Teams Child Welfare, Juvenile Justice, Developmental Disabilities, local public health, chemical dependency treatment programs, outdoor recreation programs, service clubs, parents/family members and caregivers on student's team as well as other agencies that enhance the overall health of families and the community	Agreements signed by key agency individuals/decision makers Cross system referral process addressed in agreements Agreements are "working" documents Revisit agreements at a minimum every 2 years

<p>Indicator 2:</p> <p>Connection to appropriate and local resources and advocacy for families</p>	<p>Therapist meets parents at school after referral</p> <p>Family members are part of sessions for student treatment</p> <p>Parents are trained and used as mentors for other parents who experience systemic struggles</p>	<p>Informational meetings are held with local agency representation to discuss program access</p>	<p>Early intervention/doesn't require an open CPS case to get services</p>	<p>Parents choose providers and team members</p>	<p>Use family focus groups to define education/mental health needs of students to strategize who the players should be</p>	<p>Agreements should reflect family centered approach</p>
<p>Indicator 3:</p> <p>Individual voices are encouraged and valued as equal partners in program development and improvement</p>	<p>Local health clinics, Primary Care Providers offices; School-based health clinics</p>	<p>Parents are used as experiential trainers at public meetings</p>	<p>Mental health services provided in the home as much as possible</p>	<p>Parents are encouraged to drive the treatment process</p>	<p>Community connections defined by community members</p>	<p>Agreement addresses how the voice of the student and family will be recognized throughout the community</p>
<p>Indicator 4:</p> <p>Services are provided in a safe and healthy environment</p>	<p>Space provided by district for MH therapists to allow for individual and group work with students</p>	<p>District provides space for community gatherings</p>	<p>Parents make decisions as to where team meetings are held</p> <p>Services provided in school environment and include teachers</p>	<p>Services provided in the language and culture of the student/family</p>	<p>Use a variety of community member engagement and holding meetings at partner agencies, when appropriate as a show of community support for mental health needs</p>	<p>Wraparound model; therapeutic respite program through licensed foster homes</p>

II. Practice: The school and mental health providers coordinate training for school staff, communities, and families

Evidence: (Training)	Public Announcements	Knowledgeable Trainers (credentials/ experience)	Environment/ Culture	Culturally/ Linguistically Competent Staff	Training Materials	Alternative Training Materials and Format
Indicator 1: <i>Training opportunities are evident</i>	Announcements are mailed out to all families who have children enrolled in the district Other partnering agencies host and sponsor events and help with publicity	IEP Training by Special Education Directors; MH and DD training by project managers District staff is trained to identify mental health needs and access routes to services	Written policies regarding access to mental health services reflects appropriate language and cultural norms for the community	Training is provided in various languages for all community members Parents are co-trainers and partners in training process	Include a variety of community entities and publications, including criminal justice system, in preparing curriculum and training	Experiential training opportunities provided when possible
Indicator 2: <i>Training provided is accessible to all individuals</i>	Fliers are posted in prominent locations throughout the community	Trainers have common experiences with those they train Guest speakers (national and local experts) are invited to community wide information sharing Tap into community expertise	Training occurs where one can reach the most people at any one time All meetings and trainings are held in ADA approved facilities	Training available at public mental health agency and at local school buildings on the identification and treatment options for students with mental disorders Translators are provided for ELL families	Reflects the various languages of the community served by the mental health agencies	Translators available Materials in languages appropriate for all community members Training provided whenever deemed necessary

Indicator 3: <i>Trainers have proper knowledge base</i>	Resumes/vitas of trainers presented as part of publications	Mentors are available for coaching and guidance, e.g., parent to parent, student to student programs	Training based on “needs” data gathered through formalized assessment of community needs	Mentors reflect the culture and ethnic backgrounds of individuals they mentor	Use researched-based curriculum that can be “tweaked” to meet local needs	Seek new and innovative staff and materials through consultation with other mental health agencies and districts
Indicator 4: <i>Ongoing training to provide continued learning</i>	Trainings published as far in advance as possible to provide adequate notification for individuals to attend	Appropriate trainers recruited to meet the assessed needs of the community	Trainings are available throughout the calendar year	Ongoing quest for new and innovative teachings by cultural minority individuals	Develop materials for the year that can be added to as needed to meet the needs of the community with regard to mental health	Continue to be open to new learning in the field of mental health and how it affects a student's ability to learn

III. Practice: Mental health providers and school staff work together to provide an integrated and comprehensive array of mental health services and educational opportunities

Evidence: (Integrated Services)	Stated Student Outcomes	School Schedule (time and place)	Community/School Teams	Planning/ Implementing Meeting Notes	Interagency Agreement/MOU/Funding Streams
Indicator 1: School wide programs	<p>Stabilize student within school environment.</p> <p>Training on mental health issues as related to students is available for ALL school staff (including janitorial and transportation staff)</p> <p>Interventions are at appropriate level of need</p>	<p>School sponsors mental health seminars as part of school wide programs</p> <p>Mental health awareness week is used as a launching point for training and appropriate activities</p> <p>Therapy made available in school and at home based on the needs of the family</p>	<p>Interagency staffing team for most complex students</p> <p>Teachers and administrators trained on how mental health can affect student performance – signs to watch for when a student is struggling or is at risk</p>	<p>Mental health interventionist works closely with teachers and other school personnel</p>	<p>Blended funding from several sources to achieve efficiency and avoid duplicating services from various providers</p> <p>Schools have identified funds for students in need and at risk as provided by Title 1 and state funded programs, e.g., Readiness to Learn, Twenty First Century Learning Centers, Family Resource Centers, etc.</p>

<p>Indicator 2:</p> <p>Positive behavior supports</p>	<p>Strength based assessments are used for behavior modification</p> <p>Student mentors are used to support struggling students</p> <p>Schools have a priority of addressing the needs of the whole student including social, physical, and emotional needs</p> <p>Student mental health services are provided in the school building outside normal school operation hours</p> <p>Agreements focus on the outcomes of health needs of the student/family</p>	<p>Service available on school days/weekends</p> <p>Community mental health counselors housed at schools</p> <p>Schools to provide space for mental health services</p> <p>School buildings remain available after hours and on weekends for community based mental health activities</p> <p>Agreements indicate when school building may be available for use by community partners</p>	<p>Clinicians work with classroom teachers as needed and serve as consultants</p> <p>Mental health liaisons assigned to districts from public and private mental health centers</p> <p>Parents are notified regarding mental health services</p> <p>Community partners are made aware of school building availability</p> <p>Negotiate agreements with all community partners</p>	<p>Constant available consultation with teacher</p> <p>Emergent service access is clearly known by all staff</p> <p>Provide tutoring for students</p> <p>Provide one-on-one classroom support.</p> <p>A plan for hours of availability of school district space is made in advance</p> <p>An agreement for hours of availability is made based on the needs for community access</p> <p>A clear role definition is spelled out in the Interagency agreement</p>	<p>Schools partner with mental health agencies by providing space as needed and negotiated</p> <p>Space provided after school hours. Schools provide janitorial services and supervision of physical space</p> <p>Allow sufficient time for negotiations to occur</p> <p>Indicate origin of all funds that are part of the agreement</p> <p>Indicate what process will be in place regulating how funds will be used and who will be the decision maker(s) for expenditures</p>
<p>Indicator 3:</p> <p>Mental health services are provided on school grounds.</p>					
<p>Indicator 4:</p> <p>Mental health service access extends beyond the school day.</p>					
<p>Indicator 5:</p> <p>Interagency agreement/MOU is reviewed/revised periodically.</p>					

Indicator 6: System in place for sustainability.	Produce a mission statement that is clear and shows the intent of continuation	School continue to budget funds to continue building operation after hours	Team relationships are the strength that keep the focus of the mission	Community partners recognize the importance of ongoing planning and create time for that purpose	Funding streams and processes remain in place for the duration of the agreement and adjusted as needed
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IV. <u>Practice</u> : The mental health providers and schools coordinate data collection and analysis.			
Evidence: (Data)	Stated Student/Family Outcomes	Data Collection System	Interagency Agreement/MOU
Indicator 1: <i>Agreement to share data is in place</i>	Agreement keeps student well being as focus	Integration of data system requires interagency agreements that include confidentiality rules	Agreements are necessary to coordinate collection and analysis.
Indicator 2: <i>Data used to establish benchmarks</i>	Data sources are IEPs, grades, test scores, WASL scores, attendance, behavior indicators (detentions and suspensions), number of students served	Benchmarks are established by community team Parent, teacher and student surveys are used Cross system data collection systems are aligned where possible	Benchmarks are included in MOU/Interagency agreement Data collection points are part of agreement.
Indicator 3: <i>Ongoing data collection is used to identify areas for program improvement</i>	Parents and community members are utilized to analyze data as a means toward quality improvement	Each agency uses the data for their own internal quality improvement process	Use data and results/outcomes to encourage replication.

Exhibit 8

Mental Health Evaluation Template (Activities that Promote Promising Practices, 2007)

Mental Health Planning and Evaluation Template

National Assembly on School-Based Health Care

3/05/07

The National Assembly on School-Based Health Care (NASBHC) in partnership with the Center for School Mental Health Analysis and Action (CSMHA) developed the Mental Health Planning and Evaluation Template (MHPET) to systematically assess and improve the quality of mental health services delivered within school-based settings. Originally conceived as a tool to be applied in school-based health centers (SBHCs), the MHPET has earned recognition as relevant in evaluating activities and services across the field of school-based mental health. The MHPET is a 34 indicator measure that operates as an assessment tool to target areas of strength and improvement in school-based mental health quality. The MHPET is organized into eight dimensions: operations; stakeholder involvement; staff and training; identification, referral, and assessment; service delivery; school coordination and collaboration; community coordination and collaboration; and quality assessment and improvement.

Assumptions

The MHPET is based on three major assumptions:

1. The activities and services to be evaluated have the support of the sponsoring organization, and the school and community being served.
2. It is not the sole responsibility of mental health service providers to achieve the indicators. Rather, it is a shared responsibility of the providers, sponsoring organization, school, family, community, and youth partners.
3. If evaluating the mental health services within a SBHC, it is assumed that the SBHC has adopted the NASBHC *Principles and Goals of School-Based Health Care* (http://www.nasbhc.org/APP/APP_SBHC_Principles1.htm).

Rating Instructions

- It is recommended that at least three individuals actively involved in the planning and delivery of mental health services complete the tool and provide ratings.
- Raters should represent a diverse group of providers and collaborators, including: mental health providers, program managers, health care providers, and school staff (e.g. counselors, teachers, administrators).
- Raters select the number that best reflects the degree to which that the item is implemented:
 - A. Ratings should honestly reflect present status and raters should attempt to avoid the positive bias common when using such rating methods (i.e., rating services higher than actually exist).
 - B. Many indicators have multiple components. Assign a rating based upon all of the components described in the indicator that are currently in place or not in place.
 - C. Indicators should be **rated 1 if the qualities and/or characteristics described are not at all in place**. For those indicators that have multiple components, meeting none of the components would merit this rating.
 - D. Indicators should be **rated 6 if the qualities and/or characteristics described are fully in place**. For those indicators that have multiple components, meeting all of the components would merit this rating.
 - E. Indicators should be **rated “DK” (don’t know) if the rater is not adequately informed to assess the specific indicator**.
- Raters compute the final score for each indicator based upon the average of all raters’ scores.

Mental Health Quality Improvement

- A column is provided to note **targeted areas for improvement** (those indicators with scores that are low relative to other indicators or are rated unsatisfactory by the team of raters).
- A compendium of information and resources is currently being developed to provide more in-depth guidance for program improvement efforts within each dimension (see www.nasbhc.org).
- After an identified period of program improvement activity (every 6-12 months recommended), the MHPET should again be completed as instructed above (by the same raters who participated in the initial assessment) in order to assess progress.

Dimension 1: Operations	Not at all in place					Fully in place	Don't Know	Targeted for Improvement
1. Mental health staff works in a confidential space and accesses dedicated phone lines and file cabinets that can be locked to ensure privacy of records.	1	2	3	4	5	6	DK	
2. A system is in place to perform administrative functions such as: client scheduling, data management, and documentation.	1	2	3	4	5	6	DK	
3. Following legal and professional guidelines, appropriate case records are developed and maintained, with methods to ensure privacy and confidentiality.	1	2	3	4	5	6	DK	
4. There are clear protocols and supervision for handling students' severe problems and crises (e.g., suicidal ideation, psychosis, abuse/neglect).	1	2	3	4	5	6	DK	
5. Mental health services adhere to clear policies and procedures to share information appropriately within and outside of the school and to protect student and family confidentiality.	1	2	3	4	5	6	DK	

Dimension 2: Stakeholder involvement	Not at all in place					Fully in place	Don't Know	Targeted for Improvement
6. Mental health activities and services have been developed with input from students, school leaders, school staff, families and other community members.	1	2	3	4	5	6	DK	
7. Families are partners in developing and implementing services.	1	2	3	4	5	6	DK	
8. Teachers, administrators, and school staff understand the rationale for mental health services within their school and are educated about which specific barriers to learning these services can address.	1	2	3	4	5	6	DK	

Dimension 3: Staff and training	Not at all in place					Fully in place	Don't Know	Targeted for Improvement
9. Mental health staff has completed accredited graduate training programs.	1	2	3	4	5	6	DK	
10. Mental health staff is licensed in a mental health profession or is actively pursuing licensure and receiving required supervision toward licensure.	1	2	3	4	5	6	DK	
11. Mental health staff receives training and ongoing support and supervision in implementing evidence-based prevention and intervention in schools.	1	2	3	4	5	6	DK	
12. Mental health staff receives training, support and supervision in providing strengths-based and developmentally and culturally competent services.	1	2	3	4	5	6	DK	

Dimension 4: Identification, referral, and assessment	Not at all in place					Fully in place	Don't Know	Targeted for Improvement
13. Mental health service providers work with the school to effectively identify youth who present or are at risk for presenting emotional and/or behavioral difficulties.	1	2	3	4	5	6	DK	
14. Mental health service providers and the school have adopted a shared protocol that clearly defines when and how to refer students.	1	2	3	4	5	6	DK	

Dimension 4: Identification, referral, and assessment (continued)	Not at all in place					Fully in place	Don't Know	Targeted for Improvement
15. Mental health staff responds rapidly to referrals and informs school staff, health staff and/or family members on the status of referrals	1	2	3	4	5	6	DK	
16. The mental health intake process is comprehensive while minimizing barriers to service for students and their families.	1	2	3	4	5	6	DK	
17. Mental health staff uses brief, validated measures of behavioral and emotional health including risk behaviors (e.g. substance abuse) and strengths, to enhance initial, ongoing, and outcome evaluations.	1	2	3	4	5	6	DK	

Dimension 5: Service Delivery	Not at all in place					Fully in place	Don't Know	Targeted for Improvement
18. A range of activities and services, including school-wide mental health promotion, prevention, early intervention and treatment services are provided for youth in general and special education.	1	2	3	4	5	6	DK	
19. Mental health prevention and intervention services are empirically supported or based on evidence of positive impact.	1	2	3	4	5	6	DK	
20. Mental health activities and services are designed to meet the needs of culturally and linguistically diverse groups.	1	2	3	4	5	6	DK	
21. Psychiatric consultation is available to provider staff to assist in the assessment and treatment of youth with serious and/or complex mental health issues.	1	2	3	4	5	6	DK	
22. Treatment plans are uniformly completed and accurately match program services to the presenting needs of students and their families.	1	2	3	4	5	6	DK	
23. Through peer and case consultation and other mechanisms, treatment plans and implemented strategies are frequently reviewed and adjusted to ensure that services are being delivered to address the most important problems/issues.	1	2	3	4	5	6	DK	

Dimension 6: School coordination and collaboration	Not at all in place					Fully in place	Don't Know	Targeted for Improvement
24. Mental health staff develops and maintains relationships and participates in training and meetings with educators and school-employed mental health staff.	1	2	3	4	5	6	DK	
25. Mental health staff provides consultation services to teachers, administrators and other school staff.	1	2	3	4	5	6	DK	
26. Mental health staff coordinates efforts with school-employed mental health/health professionals (including school-based health care providers if present) to ensure that youth who need services receive them and to avoid service duplication.	1	2	3	4	5	6	DK	
27. Interdisciplinary meetings and training are regularly held with all health (if present) and mental health staff of the program.	1	2	3	4	5	6	DK	
28. Mental health and health staff (school or community based) provides mutual support and cross referrals (i.e., health staff assess students for mental health issues and refer them to mental health staff and vice versa).	1	2	3	4	5	6	DK	

Dimension 7: Community coordination and collaboration	Not at all in place					Fully in place	Don't Know	Targeted for Improvement
29. A regularly updated directory is maintained to assist students and families in connecting to relevant health, mental health, substance abuse, academic and other programs or resources in the school and the community.	1	2	3	4	5	6	DK	
30. Services are coordinated with community-based mental health and substance abuse organizations to enhance resources and to serve students whose needs extend beyond scope or capacity.	1	2	3	4	5	6	DK	
31. Services are coordinated with community-based social service and advocacy organizations that are familiar with the culture and language needs of diverse student and family groups within the school.	1	2	3	4	5	6	DK	

Dimension 8: Quality assessment and improvement	Not at all in place					Fully in place	Don't Know	Targeted for Improvement
32. Guidance is received on mental health programming from stakeholders including youth, families, school staff, and community leaders who are diverse in terms of race/ethnicity and personal/cultural background.	1	2	3	4	5	6	DK	
33. A stakeholder-informed mental health quality assessment and improvement (QAI) plan is implemented that includes measures of consumer satisfaction, individual student outcomes (e.g., measures of behavioral or emotional health), and school-related outcomes (e.g., attendance, behavior, academic performance).	1	2	3	4	5	6	DK	
34. Findings from the QAI plan are used to continuously improve services.	1	2	3	4	5	6	DK	

Note: Adapted from a framework for quality assessment and improvement for the project, *Enhancing quality in expanded school mental health*, National Institute of Mental Health, #1R01MH71015-01A1; 2003-2006 (PI, M.Weist). This project has been supported by the Center for School Mental Health Analysis and Action (<http://csmha.umaryland.edu>) funded by the Health Resources and Services Administration and co-funded by the Substance Abuse and Mental Health Services Administration. Dimensions and indicators for the MH-PET were developed by workgroup members: TJ Cosgrove, Missy Fleming, Linda Juszcak, Julia Lear, Chris Reif, John Schlitt, Deidre Washington, and Mark Weist, with consultation to the work group provided by Steve Adelsheim. Additional sources used to develop indicators for the MH-PET dimensions include: the *NASBHC CQI Tool*, Linda Juszcak, Doris Pastore, Christopher J. Reif, *Bright Futures in Practice: Mental Health – Vol. II*, National Center for Education in Maternal and Child Health, Jellinek M, Patel BP, Froehle MC, eds. 2002, *Taking Control: Designing Integrated Mental Health Services in School-Based Health Centers*, NY State Dept of Health, School Health Program, Rose Starr, and *Quality of Healthcare for Children and Adolescents: A Chartbook* (Commonwealth Fund, 2004; see www.cmf.org).

Exhibit 9

Review of Literature

This portion of the resource guide provides information about how schools can successfully fund and sustain school-based mental health (SBMH) services. The majority of this information has been adapted from a publication called *Advances in School-Based Mental Health Interventions: Best Practices and Program Models* (Calfee, 2004). Other relevant resources are outlined and summarized as well.

Understanding, Funding, and Sustaining School-Based Mental Health Programs

Since the 1980s, the field of children's mental health has shifted from institutional to community-based interventions. Schools are becoming increasingly involved in these community-based systems by providing mental health services to students. However, schools are rarely successful in providing SBMH services unless they have learned how to navigate the mental health system and establish sustainable funding mechanisms for programs. Calfee (2004) describes a six-step process that can help schools understand, fund, and sustain SBMH services.

These six steps are:

1. Understand the shift from community-based to SBMH services.
2. Understand the emerging models for delivering SMBH services.
3. Examine the barriers to funding SMBH services.
4. Determine a funding strategy.
5. Identify funding sources.
6. Anticipate change as part of the funding plan.

Step One: Understand the Shift from Community-Based to School-Based Mental Health Services.

The United States Mental Health System includes a variety of services and interventions for people with mental illnesses. The system is comprised of four private and public sectors:

- Specialty mental health sector: “consists of mental health professionals such as psychiatrists, psychologists, psychiatric nurses, and psychiatric social workers who are trained specifically to treat people with mental disorders.”
- General medical/primary care sector: “consists of health care professions such as general internists, pediatricians, and nurse practitioners in office-based practice, clinics, acute medical/surgical hospitals, and nursing homes.”
- Human services sector: “consists of social services, school-based counseling services, residential rehabilitation services, vocational rehabilitation, criminal justice/prison-based services, and religious professional counselors.”
- Voluntary support network sector: “consists of self-help groups.”

In 1999, the Surgeon General of the United States reported that children were receiving fragmented and inadequate care from these public and private sectors. As a result, The Surgeon General called for coordinated, community-based services for children and suggested that schools assist in delivering comprehensive mental health services to children (United States Department of Health and Human Services, 1999).

Step Two: Understand the Emerging Models of Organization for Delivering School-Based Mental Health Services.

In order to conceptualize how mental health services are provided in schools, it is important to identify three models of SBMH delivery. These three models depict points on a continuum of care and help determine each school’s potential range of services and funding sources.

Model one is called the, Traditional School–Community Relationship. Within this model, school personnel meet basic mental health needs, but refer children and families to community resources. Community-based programs are responsible for children’s mental health issues and schools are responsible for children’s academic performance.

The second model is called the, School–Community Partnership. Within the context of this model, schools provide school-based or school-linked mental health services for special needs students. When schools cannot provide sufficient SBMH services, they refer children to community-based systems.

Model three, the School-Community Collaboration, describes schools where mental health is a top priority. Within this model, schools offer community-coordinated mental health services to all students who demonstrate moderate to severe mental health problems. Examples of school-community collaboration include SBHCs (which meet physical and mental health needs of students).

Step Three: Examining the Barriers to Funding School Based-Mental Health Services.

Several major barriers prevent communities and organizations from offering mental health services which meet the complex needs of children. In order to be funded for a broad range of SBMH services, providers must:

- Navigate the maze of funding streams and identify the best sources.
- Provide documentation of the impact of mental health services on children (for example, positive outcomes associated with children who receive a particular service).
- Establish communication between providers and schools.
- Be aware of funding stream or policy limitations which restrict service delivery to a single population.
- Be cautious about establishing service eligibility criteria which prevent children and families from receiving services elsewhere in the mental health system (e.g., ensure that families are not excluded from other services when they enroll in SBMH care).

Request funding for desperately needed services, not programs which duplicate other community resources (Calfee, 2004).

Step Four: Determining a Funding Strategy.

According to the Center for the Study of Social Policy (2000), there are four ways to fund SBMH services:

- Redeployment involves shifting available program funds from one type of program to another.
- Refinancing consists of freeing funds from less beneficial programs for reinvestment in new programs.
- Restructuring consists of shifting state dollars to federal funds.
- Raising revenue involves producing new funding for SBMH services.

Step Five: Identifying Funding Sources.

When schools are interested in raising revenue or producing new funding for SBMH services, funding is often obtained from a variety of sources including publicly funded federal grants and patient care reimbursement, publicly funded state/local grants, or privately funded grants. The most successful SBMH programs receive funding from government and community partners (Swider and Valukas, 2004).

Examples of Federal Funding Sources:

- Title XI of the Improving America's Schools Act of 1994.
- Children's Mental Health Services (Section 565(f))—Comprehensive Community Mental Health Services for Children and Families Program.
- Section 330 of the Public Health Service Act (Community Health Centers or Health Centers—Healthy Schools, Healthy Communities Program).
- Community Mental Health Services Block Grant (Title XIX, Part B, Subpart 1 of Public Health Service Act).
- Section 1532 of the Drug-Free Communities Act.
- Head Start—United States Department of Health and Human Services.
- Individuals with Disabilities Education Act.
- Section 501 of the Public Health Service Act—Funding through the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), and Center for Substance Abuse Prevention (CSAP).
- Maternal and Child Health Services Block (Title V of the Social Security Act).
- Medicaid (Title XIX of Social Security Act).
- Safe and Drug-Free Schools Communities Act (Title IV of the Elementary and Secondary Education Act).
- State Children's Health Insurance Program (Title XXI of the Social Security Act).
- Substance Abuse Prevention and Treatment Block Grant (Title XIX, Part B, Subpart II of the Public Health Service Act).
- Tax Credit/Tax Deduction for Medical Expenses/Tax Exclusion for Employer Contributions (Sections 32, 213, 105, and 106).

Examples of State/Local Funding Sources:

- State General Revenues.
- State (and federal) Maternal Child Health Block Grant (Title V of Social Security Act).
- City/County Monies.
- County Tax Revenue.

Examples of Private Funding Sources:

- Foundations.
- Institutions.
- Corporations.
- In-Kind Contributions from Community Agencies and/or Collaborators.
- Insurance Companies.
- Community and Civic Organizations or Associations.
- Hospitals.

Funding Web sites:

Catalog of Federal Domestic Assistance GrantsWeb
www.cfda.gov
<http://www.research.sunysb.edu/research/kirby.html#index>

Federal Register Notices of Funding Availability
<http://www.access.gpo.gov> <http://ocd.usda.gov/nofa.htm>
<http://www.ed.gov/offices/OCFO/grants/forecast.html>

Snapshot from SAMHSA Healthy Youth Funding Database
<http://www.samhsa.gov>
<http://www2.cdc.gov/nccdphp/shpfp/index.asp>

School Grants The Finance Project
<http://www.schoolgrants.org> www.financeproject.org

The Foundation Center
www.fdncenter.org

Step Six: Anticipating Change as Part of the Funding Plan.

In order to sustain SBMH services, it is important to design an adaptable funding plan. In particular, funding should allow for changes in the field of mental health (i.e., programs can be updated to match new research findings or legislation).

References

Calfee, C. S. (2004). The basics of organizing and funding school-based mental health services. In K. Robinson (Ed.), *Advances in School-Based Mental Health*. Kingston, NJ: Civic Research Institute.

Swider, S. M. and Valukas, A. (2004). Options for sustaining SBHC. *Journal of School Health*, 74(4), 115–118.

United States Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Washington, DC: Author. Available: <http://www.mentalhealth.org/features/surgeongeneralreport/home.asp>.

Other General Resources

The University of California Los Angeles' Center for Mental Health in Schools offers resources and publications online. Information is presented in a variety of formats including selected journal articles, policy reports, newsletter articles, training and presentation resources, resource packets, and center reports. <http://smhp.psych.ucla.edu>

The University of South Florida's Research and Training Center for Children's Mental Health has developed a guide for decision-makers engaged in developing and implementing SBMH services. This resource (1) describes the principal models and approaches identified in the literature from mental health and education, (2) critiques the empirical support for the approaches described, and (3) suggests how science, policy, and practice can be integrated to achieve effective school-based mental health service systems through the adoption of the public health model. <http://rtckids.fmhi.usf.edu/rtcpubs/study04/default.cfm>.

The University of Maryland's Center for Mental Health Assistance provides electronic resources online. Web site content includes resource packets, system of care resources, center meeting notes, research articles, and legislative updates. <http://csmh.umaryland.edu/who>.

Other Resources by Category

Mental Health in Schools

Adelman, H.S. (1996). Restructuring education support services and integrating community resources: Beyond the full service school model. *School Psychology Review*, 25 (4), 431–445.

This article highlights major gaps in the movements to restructure education and community health and social services in the United States. The paper also discusses how to address barriers to learning, how to link community social service reform to schools, and the importance of a comprehensive integrated continuum of services.

Adelman, H.S., Taylor, L., Weist, M.D., Adelsheim, S., Freeman, B., Kapp, L., Lahti, M., and Mawn, D. (1999). Mental health in schools: A federal initiative. Children Services: Social Policy, Research, and Practice, 2, 99–119.

This journal article describes a major initiative entitled Mental Health of School Age Children and Youth implemented in 1995 by the Maternal and Child Health Bureau's Office of Adolescent Health in the United States Department of Health and Human Services. This article outlines two national centers and five state projects, briefly explores models developed by the state projects, and highlight some implications of the initiative. Keywords: policy, models, initiatives, mental health, school, children, youth, adolescents, youth policy, health policy, standard based, reform, school support, learning, support, school, reform, strategies, and standard based reform.

Andis, P., Cashman, J., Oglesby, O., Praschil, R., Adelman, H., Taylor, L., and Weist, M. (2002). A strategic and shared agenda to advance mental health in schools through family and system partnerships. The International Journal of Mental Health Promotion, 4 (4).

The paper reviews data on the gap between young people who need and young people who receive mental health care. The fact that need far outstrips available resources underscores the importance of moving forward a shared agenda that builds a coalition of shared values and goals among families, school, mental health agencies, and other community programs and stakeholders. The importance of a coordinated public health approach, emphasizing broad systems enhancement, early intervention, and more intensive programs and services, is emphasized, and recommendations for strategic action at local, state, and national levels are presented.

Prodente, Christine A.; Sander, Mark A.; Weist, Mark D. (2002). Furthering support for expanded mental health programs. Children's Services: Social Policy, Research and Practice, 3 (5), 173–188.

Expanded school mental health programs provide a full array of mental health services (assessment, treatment, prevention) to youth in special and regular education in schools, based on partnerships between schools and mental health agencies and programs in the community. Despite the rapid growth of these programs in recent years and increasing evaluation and early research findings documenting their advantages and effectiveness, they face a number of challenges that can hinder their growth and make it difficult to attain communitywide support. In this article barriers to the development and growth of expanded school mental health programs are highlighted and recommendations and specific strategies for addressing concerns and enhancing support for the programs are provided. Underlying all of the strategies presented is the importance of establishing collaborative partnerships with stakeholders (e.g., educators, families, community leaders, funding agencies, and mental health providers) characterized by mutual respect and effective communication.

Establishing SBMH Programs

Acosta, O., Tashman, N., Prodent, C., and Proesch, E. (2002). Establishing successful school mental health programs: Guidelines and recommendations. In H. Ghuman, M. Weist, and R. Sarles (Eds.), Providing mental health services to youth where they are: School and other community-based approaches (pp. 57–74). New York: Brunner-Routledge.

This book chapter serves as a blueprint for the development and implementation of SBMH programs. In particular, the article discusses activities that should be completed before, during, and after programs are implemented in a school setting (e.g., needs assessment, resource mapping, program structure development, staffing, and quality assurance).

Jennings, J., Pearson, G., and Harris, M. (2000). Implementing and maintaining school-based mental health services in a large urban school district. Journal of School Health, 70 (5), 201–206.

The Dallas (Texas) Public Schools established the first SBHC in the United States in 1969. In 1993 a partnership between two school principals, a school mental health professional, and the medical director of the county mental health center was the impetus for the first comprehensive school-based mental health center in Texas. In 1995 the programs joined together as Youth and Family Centers (YFCs) to provide physical health, mental health, and other support services to students and their families. The ten strategically located school-based centers are directed by licensed mental health professionals employed by the district who lead a multidisciplinary team of physical health and mental health providers. Students served by the YFCs have fewer discipline problems, course failures, and school absences.

Lim, C. and Adelman, H.S. (1997). Establishing school-based collaborative teams to coordinate resources: A case study. Social Work in Education, 19 (4), 266–278.

Organization of a school's internal support programs and services (offered by psychologists, nurses, counselors, school social workers, and special education staff) is an important but often ignored facet of the services integration movement. This article presents a case study of the establishment of school-based collaborative teams designed to coordinate and enhance a school's support service resources. Factors contributing to the establishment of resource coordination teams were strong commitment from participants, successes leading to tangible results, and effective guidance and support from a change agent. Implications for expansion of the role of school social workers are explored, as are recommendations for how school social workers can be prepared to assume these roles.

Weist, M.D. (2005). Fulfilling the promise of school-based mental health: Moving toward a Public mental health promotion approach. *Journal of Abnormal Child Psychology*, 33 (6), 735–741.

School-based mental health (SBMH) programs and services are growing progressively in the United States for many reasons. However, the SBMH field is young and tenuously supported, and challenges are being confronted on many levels. There are major needs to continue to bring research-supported interventions into schools, and to better equip educators and mental health programs and staff in schools to function effectively. Articles in this special issue present the many challenges well and point to important directions for advancing SBMH. To truly advance the field, a Public Mental Health Promotion approach is needed. Elements of this approach, in advancing training, quality assessment and improvement (including empirically supported practice), and advocacy and policy influence are discussed, as are strategic connections to the Community Science perspective and to the development of a growing Community of Practice in SBMH.

Funding SBMH Programs

Center for Health and Health Care in Schools. Nine State Strategies to Support School Based Health Centers. Available:
<http://www.healthinschools.org.sbhcs/papers/ninestrategies.asp>.

In 1993, nine states were awarded Making the Grade grants to develop financial and other strategies to foster replication of a SBHC. This report details the financial strategies used by Vermont, Rhode Island, Oregon, North Carolina, New York, Maryland, Louisiana, Connecticut, and Colorado, as reported in a meeting of grant recipients in 1998. Following an executive summary, the report describes the strategies taken by each state. The report notes that with the exception of Louisiana, these states directed their attention to linking SBHC to Medicaid managed care arrangements, reflecting the belief that SBHC had to align themselves with mainstream health care. In addition, the report indicates that the key to a successful state strategy is in clarifying the public purpose of SBHC, and that the basic models for SBHCs (medical home, public health, and an add-on model) reflect the centers' purposes. The report concludes by noting that the experiences of the nine states demonstrate a variety of efforts to secure access to existing public and private funding streams as well as generate state fiscal support for SBHC. The onus is on the centers to prove their worth, a task requiring documentation of the number of children served, their insurance status, and services provided. This information is needed to lobby for inclusion in health plan networks, and for state or local revenues to cover the services often excluded from insurance coverage. (Three appendices contain the policy questions addressed by the states, list the meeting participants, and include the meeting agenda).

Johnson, K., and Kaye, N. (2004). Using Medicaid to support young children's healthy mental development. Commonwealth Fund. New York, NY.

This report examines both why and how Medicaid can support children's healthy mental development, including a discussion of how states can use Medicaid to better support young children's social/emotional development even in the current economic climate.

Robinson, G., Barrett, M., Tunkelrott, T., et al. (2000). School-based mental health services under Medicaid managed care (DHHS Publication No. [SMA] 00-34560. Rockville, MD: Center for Mental Health Services, Substance Abuse, and Mental Health Service Administration.

This study sought to learn how schools and providers of school-based mental health services work with Medicaid managed care organizations. To that end, it observed the experiences of several states and local communities in providing for the inclusion of school-based mental health services in managed care contracts. The study also explored options and models for including school-based mental health services within managed care; examined financing and reimbursement issues that might affect the viability and expansion of such services; and assessed alternative ways to maintain and expand school-based mental health services within the managed care environment.

A multidisciplinary team with experience in mental health, school health, and health care financing conducted the study. Site visits were conducted in three states: New Mexico, Maryland, and Connecticut. The chosen sites had well-established school-based mental health programs and were actively implementing managed care contracts with local Medicaid managed care organizations (MCOs).

The study revealed that providers of school-based mental health services and administrators of the programs struggle to solve numerous logistical and administrative problems that are inherent to the startup of new business arrangements for service delivery, service coordination, and reimbursement. The partnerships between school-based programs and managed care organizations are relatively new. Many of the problems associated with these new partnerships are likely to be growing pains, which will resolve over time. While study respondents had doubts about the feasibility and value of contracting with managed care organizations, they acknowledged that working with these organizations brings school-based mental health programs into the main-stream of health care financing, establishes credentials of school-based providers, and improves accountability.

The main study conclusions are that school-based mental health programs need more support to effectively and efficiently implement managed care contracts, and that policy leaders should consider other options for capturing third-party insurance revenue in addition to traditional behavioral health managed care network provider contracts. Specific study findings include the following:

1. At the study sites, the sponsoring agencies for school-based mental health services successfully negotiated contracts with Medicaid managed care plans. However, these arrangements varied greatly in their complexity, ease of implementation, and results regarding revenue generation and barrier-free access to mental health services.
2. Schools that had mental health clinicians prior to managed care still had those clinicians. Providers were not shifted into other service venues because of managed care network pressures or decisions to end SBHC services. Barriers to care emerged from administrative policies, not from a loss of mental health clinicians providing services in the schools.
3. Sponsoring agencies, State Medicaid agencies, and MCOs lacked understanding about the full scope and value of school-based mental health services and the role that such services can play within the overall system of care for children. The decision to collect third-party dollars through MCOs was not grounded in carefully thought-out strategic plans consistent with the philosophical base and principles supporting school-based mental health services.
4. The implementation of managed care may have changed access to community-based mental health services and may also have changed the mix of available community-based services. This affected the demand for mental health services within the school and the level of care needed by children attending school.
5. The study team observed a number of missed opportunities for enhanced coordination between school-based mental health programs and other school health services.

Study recommendations included exploring ways to help school-based mental health programs develop the needed skill and infrastructure to implement viable managed care contracts, defining other approaches to generate Medicaid revenue for school-based mental health care, and improving coordination between school mental health programs and other school health programs. The evaluation team also identified the need for further research to understand and quantify the effects of managed care on the availability and mix of community-based mental health services, and, consequently, on the demand for school-based mental health services.

Weist, M.D., Goldstein, A., Evans, S.W., Lever, N.A., Axelrod, J., Schreters, R., and Pruitt, D. (2003). Funding a full continuum of mental health promotion and intervention programs in the schools. *Journal of Adolescent Health*, 32 (6), 70–78.

The chapter focuses on “expanded school mental health” (ESMH) programs, which provide a full array of mental health promotion and intervention services to youth in general and special education through school–community partnerships. Existing evidence suggests that funding for these programs is patchy and tenuous. Many programs are being funded through fee-for-service programs, which generally only support the provision of more intensive services (e.g.,

assessment, therapy) and are associated with significant bureaucracy and other concerns (e.g., the need to diagnose students). As programs move to enhance funding for preventive and mental health–promoting activities and services, there is an increasing need for grants, contracts, and other sources of support. Progress in the national movement toward ESMH will be promoted through an interconnected agenda of quality improvement, evaluation of program effectiveness, and the advancement of advocacy. These developments will facilitate policy improvements and increased funding for the full continuum of mental health promotion and intervention in the schools.

Sustaining SBMH Programs

Adelman, H.S. and Taylor, L. (2003). On sustainability of project innovations as systemic change. *Journal of Education and Psychological Consultation*, 14 (1), 1–25.

Too many promising innovations disappear when project funding ends. As a result, interest in the problem of sustainability has increased markedly in recent years. This article explores this problem in terms of systemic change. Highlighted are basic ideas, phases, stages, steps, and lessons learned related to the planning, implementation, maintenance, and scale-up of school-based innovations. A particular emphasis is on efforts designed to enhance how schools address barriers to learning and teaching. The discussion is framed around the idea that the likelihood of sustaining any new approach is increased if it is integrated into the fabric of existing school improvement efforts.

Swider, S. M. and Valukas, A. (2004). Options for sustaining School-Based Health Centers. *Journal of School Health*, 74 (4), 115–118.

Several methods exist for financing and sustaining operations of a SBHC. Promising sources of funds include private grants, federal grants, and state funding. Recently, federal regulation changes mandated that federal funding specifically for SBHC go only to SBHC affiliated with a Federally Qualified Health Center (FQHC). Becoming a FQHC allows a SBHC to bill Medicaid at a higher rate, be notified about federal grants, and access the federal drug-pricing program. However, FQHCs must bill for services, including a sliding-fee scale based on ability to pay; develop a governance board with a majority of consumer members; provide a set of designated primary care services; and serve all people regardless of ability to pay. Private grants impose fewer restrictions and usually provide start-up and demonstration funds for specific program needs. Such funds are generally time limited, so new programs need to be incorporated into the operational budget of the center. State funding proves relatively stable, but fiscal challenges in some states made these funds less available. Using a variety of funding sources will enable ongoing provision of health care to students. Overall, SBHC should consider infrastructure development that allows a variety of funding options, including formalizing existing partnership commitments, engaging in a needs assessment and strategic planning process, developing the infrastructure for FQHC status, and implementing a billing system for client services.

Empirically-Supported Interventions in School Mental Health

This portion of the resource guide outlines school-based mental health interventions that are supported by research. The interventions are called “empirically-supported” because clinical trials have shown that these school-based practices are superior to other interventions. In particular, the American Psychological Association defines empirically-supported interventions as “a treatment with at least two clinical trials using random assignment and at least one trial by someone other than the developer” (Center for School Mental Health Assistance, 2004). Because these treatments meet such strict research design standards, the interventions are often called best practices.

It is important to note that the list of interventions described below is not exhaustive. Many empirically-supported treatments have been excluded from the lists because they are not compatible with school-based service delivery (Center for Mental Health Assistance, 2004).

Best Practices for School-Based Mental Health Interventions (by Category)

Taken from a Resource Packet developed by the Center for Mental Health Assistance, 2004.

Treatments for Internalizing Disorders: Anxiety and Depression

To date, the treatments that have been demonstrated to be effective with anxious and depressed youth all involve cognitive-behavioral therapy (CBT). Although they vary in their particular sequencing of interventions, most CBT protocols for internalizing disorders involve such specific techniques as self-monitoring of mood and physiological symptoms, engaging in pleasurable activities, use of self-rewards, relaxation and imagery, assertiveness and social skills training, and cognitive restructuring. Many of the treatments for youth with internalizing disorders also include a family component to address mood/anxiety problems among parents and to teach parents to help children use their new cognitive-behavioral skills.

Anxiety

Coping Cat (by Phillip Kendall, 1996). This 18-session group cognitive-behavioral treatment for anxiety is suitable for children ages 9–13. Single-sex groups of 3–5 youth are recommended to promote discussion of anxiety symptoms and group cohesion. Coping Cat uses the acronym FEAR (Feeling Frightened, Expecting bad things to happen, Attitudes and Actions that help, Results and Rewards) to help youth remember the cognitive-behavioral steps involved in coping. Three manuals are required to implement the approach, ranging in price from \$13–\$22.95 each; an order form for the manuals (published by Workbook Publishers) is available at the Web site: www.childanxiety.org.

FRIENDS (by Paula Bartlett, 1999). FRIENDS is a group-administered cognitive-behavioral treatment for anxiety disorders for children ages 7–11. The program is comprised of ten sessions between 45–60 minutes in length, administered on a weekly basis, with two follow-up booster sessions. There are also four optional parent sessions. Groups should be comprised of 12 or fewer youth. FRIENDS addresses the three major components of chronic anxiety symptoms: mind (i.e., cognition), body (i.e., physiological responses), and behavior (i.e., learning new coping skills). The acronym of FRIENDS is used to help youth remember coping steps for dealing with anxiety symptoms. Three manuals are necessary to implement the approach: the group leader's manual, a children's workbook, and a parents' supplement. Manuals are \$65 each, and order forms are available at the Web site: www.australianacademicpress@compuserve.com. To order by phone, dial international 61-7-3257-1176.

Depression

Stark School-Based Intervention for Depression (by Kevin Stark). This 26-session group cognitive-behavioral intervention has been tested and shown to be effective with 4–7 graders with elevated levels of depression. The treatment components include self-control techniques (e.g., self-monitoring, self-reinforcement), social skills training, assertiveness training, relaxation training, imagery, and cognitive restructuring. A family component, which focuses on increasing positive family activities and training parents to help children use their new skills, is also recommended. The treatment protocol is described in a recent book by Phillip Kendall (2000; *Child and adolescent therapy: Cognitive-behavioral procedures*) available for \$46 from Guilford Press at www.guilford.org. Or, to obtain the full treatment manual, contact Dr. Stark directly at the Department of Educational Psychology, University of Texas-Austin: kevinstark@mail.utexas.edu.

Adolescent Coping with Depression Course (by Peter Lewinsohn). The Adolescent Coping with Depression Course is a psychoeducational, cognitive-behavioral intervention for adolescent depression. The protocol consists of 16, 2-hour group sessions conducted over an eight-week period. It is designed for use with groups of 4–8 adolescents in an in-school or after-school program. It can also be adapted for use in individual therapy. The treatment sessions are conducted as a class in which a group leader teaches the adolescents skills for controlling depression. The topics covered include relaxation, engaging in pleasant activities, negative thoughts, social skills, communication, and problem solving. Each adolescent is provided with a student workbook which matches closely the course discussions and group activities. The workbook includes brief readings, structured learning tasks, self-monitoring forms, homework assignments, and short quizzes. Parents are encouraged to participate in the program by way of 9, 2-hour group sessions that are held at the same time as the adolescent group. All materials required for administering this intervention (student workbook, leaders' manual, parent workbooks) are available for free

download at the Coping with Depression Course Web site:
<http://www.kpchr.org/public/info/newacwd.html>.

Taking Action Program for Depressed Youth (by Phillip Kendall). This manual, although not itself demonstrated as an empirically-supported intervention, uses many of the cognitive-behavioral techniques used in the Stark and Lewinsohn protocols, and is suitable for elementary age children. The therapist manual (\$22.95) and student workbook (\$13) are available from Workbook Publishers; print out an order form at www.childanxiety.org.

Treatments for Externalizing Disorders: **ADHD, ODD, and CD**

As any clinician working with children knows, externalizing behavior problems such as impulsivity, aggression, noncompliance, and oppositionality are very difficult to address. According to the treatment research that is currently available, the only effective psychosocial treatments for these disorders are those that involve behavioral modifications administered consistently in the youth's natural environment by the youth's caregivers—parents and teachers. With the exception of non-comorbid youth with impulse-control problems, individual therapies for youth with externalizing behavior disorders have not been demonstrated to be effective. Moreover, group therapies that involve treating large numbers of these youth at the same time have been shown in many cases to actually make externalizing symptoms worse. This is because of a phenomenon that has been called deviancy training: groups of antisocial youth tend to teach, encourage, and reward each other for saying and doing antisocial things. In group therapy settings, it is very difficult for group leaders to maintain control over such behaviors; even when group leaders feel they are being successful in creating a pro-social environment, youth often are rewarded by their peers for acting up in group either subtly, or after the session concludes.

Attention Deficit/Hyperactivity

Cognitive-Behavioral Therapy for Impulsive Children (by Phillip Kendall and Lauren Braswell). In this group-administered treatment, youth with impulse-control problems are taught to use a systematic problem solving process to slow themselves down and brainstorm ways to respond to interpersonal and academic situations more successfully. The problem solving process is taught primarily through modeling, role-playing, and rewards for use of the new skills. The protocol calls for a minimum of 20, 50-minute sessions (more if participants need more practice in the skills) led by two therapists. An extensive reward system (using "Stop-and-Think Dollars") is employed to encourage pro-social behavior, and response costs are used for misbehavior. The treatment is designed for youth ages 9–13. As noted above, this treatment only addresses the impulsive component of ADHD, not noncompliance, disruptive behavior, or aggression that is often found in youth with ADHD; thus, this approach should be

used in conjunction with other interventions (e.g., parent training) when other symptoms commonly associated with ADHD are present. A general treatment manual describing the approach is available for \$31 from Guilford Press (www.guilford.org). The youth Stop-and-Think Workbook (\$13) and a more detailed treatment manual for group leaders (\$22.95) are also available from Workbook Publishers; download an order form at www.childanxiety.org.

Teaching Problem Solving to Students with Learning and Behavior

Problems (by Phillip Kendall and Nettie Bartel). This is the classroom-based version of the CBT for Impulsive Children described above. It is meant for youth with problems in impulsivity, self-control, or self-discipline; however, the problem solving approach is general enough to be used in normal classroom settings and can be beneficial for all youth, even those not presenting with clinical symptoms. The approach can be adapted for almost any age youth. It is comprised of 12 sessions, but more may be required in order for students to master the skills. A reward system is optional in this approach. The teacher/group leader manual is available for \$22.95 at Workbook Publishers; download an order form at www.childanxiety.org.

Oppositional Defiant/Conduct Disorder

Classroom Behavioral Reward Systems. Classroom behavioral reward systems are an essential part of addressing the conduct problems of youth who show disruptive behavior and oppositionality in the school setting. Unfortunately, there are few specific protocols available for how to reward and punish appropriate and inappropriate classroom behavior for externalizing youth. For a good overview of various strategies involving response cost systems and token economies, the book *Effective School Interventions: Strategies for Enhancing Academic Achievement and Social Competence* by Natalie Rathvon (1999) is an excellent place to start. This book is available from Guilford Press at <http://www.guilford.com>.

Defiant Children (by Russell Barkley, 1998). A comprehensive behavioral parent training course for noncompliant and oppositional children ages 3–13. Protocol includes ten modules that teach parents ways to monitor good and bad behavior, engage in positive interactions with their child, use time-out, use rewards for good behavior, and use a response cost system as punishment for inappropriate behavior. The manual includes many reproducible handouts and is available in English and Spanish. The protocol can be administered to individual parents or groups of parents. The manual is available from Guilford Press Publishers for \$37 at <http://www.guilford.com>.

Functional Family Therapy (FFT; by James Alexander). This treatment approach has been applied to many types of adolescent behavior problems and has been evaluated for conduct and substance abuse disorders. It is suitable for youths aged 11–18. The treatment focuses on family engagement and

motivation, with interventions designed to overcome hostility and negativity. The course of treatment ranges from 8 to 30 hour-long sessions over approximately three months. For more information visit the Web site: <http://www.fftinc.com>.

Helping the Noncompliant Child (by Rex Forehand and Robert McMahon).

This parent training manual is designed for oppositional children ages 3–8 years old. It focuses on teaching parents to be more effective reinforcement agents and to issue more effective commands. Parents practice their new skills with their child in the Child Game (child-directed play in which the child chooses an activity) and the Parent Game (parent chooses an activity and applies rules/limits for it). The length of treatment is flexible (parents should not continue to a new phase until skills of previous phase are mastered) but the protocol can be completed in ten sessions. Although this protocol is less extensive than Barkley's "Defiant Children," it is tailored specifically for the younger child and provides a nice discussion of how to deal with problematic situations (e.g., extremely noncompliant children, failure of gains to generalize beyond the practice games). The manual is available from Guilford Press Publishers at <http://www.guilford.com>.

Keeping Your Cool (by Phillip Kendall). This cognitive-behavioral intervention is appropriate for dealing with the aggressive behavior problems of youth exhibiting a disruptive behavior disorder. It is suitable for youth ages 10–17. The protocol calls for 17–27 sessions, depending on the youth's progress. It is designed to be administered individually, but can be implemented in small groups if highly monitored (recall the problem of grouping youth with disruptive behavior problems for interventions). The therapist manuals (\$13 and \$16.95) and student workbook (\$22.95) are available from Workbook publishing at (610) 896-9797; a video (\$45) is also available.

Videotape Parent Training (by Carolyn Webster-Stratton). This treatment is suitable for parents of younger (ages 3–10) children who are exhibiting disruptive behavior problems. The approach combines traditional parent training techniques with videotapes of actors enacting adaptive and maladaptive responses to common stressful child situations. For more information contact Dr. Webster-Stratton at cws@u.washington.edu.

Universal Preventive Interventions

Universal interventions are those designed to lower the risk for a disorder for all youth, not just those exhibiting early symptoms or risk factors. An example of a universal intervention is vaccinating all babies for smallpox. Many universal interventions are broad and target a number of problems rather than a specific disorder per se. For youth, most universal interventions are delivered to whole classrooms at a time, and as such, require the cooperation and participation of classroom teachers and school administrative personnel.

Many universal prevention programs focus broadly on enhancing children's abilities to identify and manage their emotions and to behave appropriately in interpersonal conflicts. These programs have been classified as promoting social and emotional competence. Social and emotional competence programs have been shown to reduce rates of later oppositional problems and internalizing disorders. All of these curricula are classroom-based and behavioral, involving reward systems to encourage youth to use newly acquired skills.

I Can Problem Solve (ICPS; by Roger Spivak and Myrna Shure). This universal program is designed for ages 4–12 and has shown long-term positive effects in improving aggression, frustration tolerance, and social withdrawal. Lessons are conducted daily for 20–30 minutes for younger children, and three times/week for 40 minutes for older children. A supplemental parents' manual, *Raising a Thinking Child*, is available to help parents reinforce new skills at home. Separate manuals (\$39.95 each) exist for preschool, kindergarten/early elementary (up to third grade), and later elementary school (grades 3–6); only one manual per group of children is necessary. Training (\$1,000 per site) is recommended for broad-scale (e.g., schoolwide) implementation. Manuals are available at Dr. Shure's Web site: <http://www.thinkingpreteen.com/links.htm>.

Promoting Alternative Thinking Strategies (PATHS; by Mark Greenberg). PATHS is one of the most widely used social and emotional competence programs in existence today. It is designed to be taught by the classroom teacher three times per week or more for at least 20 minutes each lesson. More than 130 lessons focusing on self-control, empathy, self-esteem, social problem solving, positive values and attitudes, and critical thinking skills are included. PATHS is designed for youth in grades K–6. The complete curricula (K–6) costs \$640 and includes a teacher's instructional manual, six volumes of detailed lessons, pictures, photographs, posters, feelings faces, and additional materials; evaluation materials are also available. Training of staff is highly recommended (30 people costs \$3,000 for two days), and ongoing support and consultation in the use of PATHS is available at additional cost. Learn more about PATHS and order it at the Web site: <http://www/dpr.org/PATHS/PATHS.html>.

Skillstreaming (by Arnold Goldstein). This prevention program, designed to enhance youths' social skills, can be used as a universal classroom or a selected small group intervention. Separate curricula exist for K–6 and 7–12 grades. Instructors can run through the entire protocol or select different component skills to meet the needs of specific youth. Cue cards are used to prompt students to use Skillstreaming strategies. To implement Skillstreaming, a therapist's manual (\$19.95), student workbook (\$12.95), student materials (\$16.95), and student skill cards (\$25) are needed. Materials are available through Research Press at www.researchpress.org.

Adolescent Transitions Project (by Thomas Dishion). This package of interventions is designed for middle school aged youth. A Family Resource Room is established within the middle school from which parent training and other supportive services can be implemented. The primary intervention involves the Family Check-Up, a 4–5 session in-home assessment of the youth’s risk for substance abuse and other problems with a detailed parent feedback session designed to motivate families to make preventive changes or seek additional services. Family Check-Ups generally occur in the summer preceding seventh grade and are available to all families who agree to participate. For more information contact Thomas Dishion at TomD@darkwing.uoregon.edu.

Project ALERT (by Phyllis Ellickson). Project ALERT is a two-year drug prevention curriculum for middle school students (ages 11–14) that has been shown empirically to reduce the onset and regular use of substances. The 14-lesson program (45 minutes per lesson), administered by classroom teachers, is designed to prevent drug use initiation and the transition to regular use. It focuses on gateway substances: alcohol, tobacco, marijuana, and inhalants. Project ALERT uses participatory activities and videos to help students establish non-drug norms, develop reasons not to use, and resist pro-drug pressures. Guided classroom discussions, small group activities, role-playing, and parent-involved homework assignments also are used. Teachers can be trained in on-site workshops or at regional centers; all curriculum materials are distributed at the workshops. For more information, contact the Web site: www.projectalert.best.org.

Be Proud, Be Responsible (by Loretta and John Jemmott). This curriculum is designed to prevent HIV and other STD infections by providing youth with information and skills to avoid engaging in high-risk sexual behaviors. It consists of six one-hour modules that can be administered as a whole (i.e., in a single day) or in blocks. The intervention is designed for small groups of 6–12 adolescents aged 11–15. The curriculum uses discussion, videotapes, role playing, and performance feedback, and can be administered by professionals or by supervised older adolescents (called peer facilitators). The curriculum can be ordered at Select Media, Inc.: (800) 707-6334 or (800) 343-5540.

Behavioral Prevention Project (by Debra Kamps). This multisetting, multimodal intervention combines classroom level interventions (academic tutoring, social skills instruction, and classroom behavior management) with in-home parent support and outreach to address negative peer student and teacher student interactions. It is designed for elementary school students. For more information send an email to csnyder@zoo.uvm.edu or contact the Web site: <http://www.air.org/cecp/preventionstrategies/behaviorprevention.htm>.

Bullying Prevention Program (by Dan Olweus). This program targets elementary and middle school students, teachers, and parents and is primarily focused on building awareness of bullying and helping students develop

cognitive skills for dealing with bullying. Screening and identification of potential bullies and victims is another component. For more information contact Dan Olweus at Olweus@psych.uib.no.

Child Development Project (CDP; by Eric Schaps). This elementary school improvement initiative is for grades K–6 and is designed to improve students' motivation for school and learning and to enhance students' resilience to later substance use. The intervention involves teachers, families, and school administrators and is focused on building a strong sense of community in the school, fostering cross-grade student relationships, and promoting parent involvement in learning. Phase One interventions focus on school climate; Phase Two focuses on curriculum and teaching style changes. To implement the program, school administrators attend a two-day training and receive materials for use in the school; costs vary depending on the size of the school. For more information, contact Denise Wood, Developmental Studies Center, at (800) 666-7270, ext. 239 or contact the Web site: <http://www.healthorg/features/hry/Programs/2-cdp/cdp.htm>.

Life Skills Training (by Gilbert Botvin). This widely-adopted universal classroom-based intervention is designed to prevent substance use among middle school students by targeting risk factors such as positive expectations for substance use, poor self image, and poor social skills. The program consists of 30 class sessions, each lasting 45 minutes. It can be administered as a concentrated curriculum (e.g., 2–3 times per week for a semester) or as an ongoing intervention throughout grades 6–8. Life Skills Training can be implemented by health educators, classroom teachers, mental health professionals, or older peer leaders. The curriculum is highly structured and user-friendly, with an average cost per student of \$21. To purchase curricular materials or to learn more, visit the Web site: www.lifeskillstraining.com or call (800) 636-3415.

Linking the Interests of Families and Teachers (LIFT; by John Reid). This universal program is designed for elementary school youth in 1–5 grades. The ten-week intervention involves parent training (group administered), social skills training, playground behavioral modification program, and techniques to enhance communication between parents and teachers. It is designed to prevent the development of oppositional and conduct problems. For more information, contact John Reid at: johnr@oslc.org.

Preparing for the Drug-Free Years (PDFY; by J. David Hawkins). PDFY is a family competency training program that promotes healthy parent-child interactions designed to reduce children's risk for early substance use. Parents attend nine weekly sessions focusing on child rearing, reducing family conflict, and positive family activities. Youth attend one session focusing on peer pressure. For more information, visit the Developmental Research and Programs, Inc. Web site at <http://www.drp.org>.

Project Northland (by Cheryl Perry). Project Northland is a three-year communitywide intervention designed to reduce adolescent alcohol use among 6–8 graders. In the first year parents and youth complete homework assignments together that pertain to adolescent alcohol use. The second year involves a peer-and teacher-led classroom curriculum, and the third year involves youth community activism to address underage drinking. For more information contact the Web site:
<http://www.colorado.edu/csvp/blueprints/promise/projectNorthland.htm>.

Project STARR (by Mary Ann Pentz). Project STARR is a multicomponent (media, school, parents, community leaders, and health professionals), communitywide intervention to prevent substance abuse. It is designed to ease youths' transition from early adolescence through late adolescence and can be implemented fully in the community within 3–5 years. The program involves mass media programming, active social learning techniques in the schools, parent education, and local policy changes. It requires a strong community/school coalition, extensive training, and ongoing technical assistance but results in a consistent community message to avoid drug use. For more information contact Karen Bernstein at (323) 865-0325.

Skills, Opportunities, and Recognition (SOAR; by Richard Catalano). SOAR is the commercially available version of the David Hawkins and Richard Catalano's Seattle Social Development Project. The intervention is a comprehensive school improvement program for middle school aged youth. For more information, contact Developmental Research And Programs, Inc. at <http://www.drp.org>.

Strengthening Families Program (by Richard Spoth). This universal, family-based intervention is designed for youth ages 10–14 and focuses on enhancing parent management skills, parent-child affective relationships, and family communication. The goal is to delay the onset of youth substance use. The intervention lasts seven weeks and involves both a parent and youth training component. For more information contact Virginia Molgaard at (515) 294-4518 or visit the Web site: <http://www.colorado.edu/cspv/blueprints/promise/iowa.htm>.

Selected Preventive Interventions

Selected interventions are those designed to alter the development of a disorder among those who are showing early signs of the disorder or who are at high-risk for developing the disorder. Examples of selected interventions would be targeting children who are sad (early sign) but not yet depressed or children with criminal parents (risk factor) who might be at-risk for developing conduct disorder.

Adolescent Coping with Stress Course (by Peter Lewinsohn). The prevention counterpart of the Adolescent Coping with Depression Course described above. This selected intervention involves a number of cognitive-behavioral techniques for youth who do not yet meet criteria for a depressive disorder but who are at high-risk for developing depression. All materials required for administering this intervention (student workbook, leaders' manual, parent workbooks) are available for free download at the Coping with Depression Course Web site:
<http://www.kpchr.org/public/info/newacwd.html>.

Family Bereavement Program (by Irwin Sandler). This is a selected intervention for children and adolescents at high-risk for depression due to the death of a caregiver. The program consists of 12 group sessions for children and adolescents to build coping skills and coping efficacy and 12 sessions for parents to build and support effective parenting during grief. Information on the program and the assessment measures are available from the investigator, Irwin Sandler, at irwin.sandler@asu.edu. Manuals for this approach are free but the developer requests that he be contacted to provide phone assistance to those who want to implement the approach.

Penn Optimism Program (by Karen Reivich). This program is designed to combat cognitive distortions and related deficits associated with depression, such as behavior problems and poor peer relations. At-risk youth who might be suitable for the program are those from households with high marital conflict, low family warmth, or elevated depressive symptomatology. Students meet in groups of 10–12 youth for 12 weeks after school (1.5 hours per week). For more information contact Dr. Reivich at Reivich@psych.upenn.edu.

FRIENDS (by Paula Bartlett, 1999). FRIENDS is a group-administered cognitive-behavioral treatment for children ages 7–11 with anxiety disorders or symptoms. The program is comprised of ten sessions between 45–60 minutes in length, administered on a weekly basis, with two follow-up booster sessions. There are also four optional parent sessions. Groups should be comprised of 12 or fewer youth. FRIENDS addresses the three major components of chronic anxiety symptoms: mind (i.e., cognition), body (i.e., physiological responses), and behavior (i.e., learning new coping skills). The acronym of FRIENDS is used to help youth remember coping steps for dealing with anxiety symptoms. The FRIENDS approach is well-manualized with easy to reproduce materials. Three manuals are necessary to implement the approach: the group leader's manual, a children's workbook, and a parents' supplement. Manuals are \$65 each, and order forms are available at the Web site:
www.australianacademicpress@compuserve.com. To order by phone, dial international 61-7-3257-1176.

Achieving, Behaving, Caring (ABC; by Pam Kay). This program is designed for children in first and second grades who showed behavioral or emotional problems in kindergarten. The intervention is focused on developing a working relationship between teachers and parents. Parents and teachers develop mutually agreed upon goals for the youth and with the help of parent liaisons (peer parents), communicate and monitor the youths' progress. Parent liaisons are recruited, trained, supervised, and paid for their participation. Child social skills training can be used to enhance the effectiveness of the program. For more information contact Pam Kay at pkay@zoo.uvm.edu or visit the Web site: <http://www.air.org/cecp/preventoinstrategies/achievingbehavingcaring.htm>.

Across Ages (by Andrea Taylor). Across Ages is a school-sponsored mentoring program for middle school youth ages 10–13. Elders (age 55 and older) serve as mentors to middle school youth and engage them in community service activities. Classroom teachers also provide life-skills training in the classroom. Positive outcomes have been achieved in improving school attendance and academic competence and in decreasing positive attitudes towards drug use. The Across Ages program requires full-time staff to administer the intervention. Training for up to 25 people occurs on-site at a rate of \$1,000/day (two days required) and is supplemented by ongoing technical assistance by telephone. Manuals that describe the approach also are available for order by emailing Dr. Taylor at andreat46@aol.com.

Behaviorally-Based Preventive Intervention (by Brenna Bry). This selected two-year program is designed for seventh graders who are at high-risk for conduct problems, substance use, or school failure. Youth who are displaying low academic motivation, family problems, or serious/frequent school discipline referrals are appropriate for this intervention. Teachers, school administrative staff, and school counselors work together to monitor student actions and reward appropriate behaviors across seventh and eighth grades. Small group sessions of 3–5 students meet on a weekly basis across the two years for support and role-playing of new skills. For more information, contact Brenna Bry at bbry@rci.rutgers.edu or visit the Web site: <http://www.colorado.edu/cspv/blueprints/promise/preventl.htm>.

Coping Power (by John Lochman). The Coping Power program targets aggressive children in the 4–6 grade years. It contains both child and parent treatment components. The Coping Power Child Component is a 15-month program with 33 group sessions. Child Component group sessions take place at children's schools (after school, before school, or during nonacademic homeroom periods) and last 45–50 minutes. A mental health clinician and school personnel co-lead group sessions of four to six children. To include a school staff person in the delivery of the program helps ensure the school's active acceptance of and involvement in the project. Each child additionally receives a total of 10–12 individual half-hour sessions at their school with an average of one individual session per month. The Coping Power Parent Component consists of 16 parent group sessions over the same 15-month

period. Parents meet in groups of 10–12 parents or parent dyads with two co-leaders. The parent component involves parent training and coping skills for parental stressors. For more information about implementing Coping Power, contact Dr. Lochman at jlochman@gp.as.ua.edu

Creating Lasting Connections (CLC; by Ted Strader, 1995). This wide scale intervention begins with mobilizing community groups (e.g., schools, churches, recreation centers, court) to identify at-risk families of youth ages 11–15. Families are recruited to participate and are provided with 20 weeks of parent and youth training focused on responding to adolescent crises and connecting to community resources. For more information, contact the Resilient Futures Network at (502) 897-1111 or visit the Web site: <http://www.healthorg/features/hry/Programs/3-clc/clc.htm>.

FAN Club (by Tena St. Pierre). This program is designed to be implemented in collaboration with the Boys and Girls Club of America (BGCA) and is focused on preventing youth substance use. The intervention involves 3 tiers of interventions: Start SMART (ages 10–12), Stay SMART (ages 13–15), and SMART Leaders (ages 14–17). Parents of youth involved in the program are given basic support to deal with stressors, and activities are provided to promote family bonding. Educational enrichment activities also are a component. For more information contact the BGCA Director of Health and Life Skills at (404) 487-5766 or visit the Web site: <http://www.healthorg/features/hry/Programs/7-fan/fan.htm>.

Project Towards No Drug Abuse (Project TND; by Steven Sussman). This is one of the only selected interventions targeting drug use that is designed for high school (rather than middle school) students ages 14–19. Youth participate in 12 in-class interactive sessions (40–50 minutes each) over the course of 4–5 weeks. The sessions focus on motivation, skills, and decision making. The program can be administered by classroom teachers; a two-day teacher training is recommended. The curriculum includes an implementation manual, student workbooks, a videotape, and pre/post-tests. For more information contact Steven Sussman at ssussma@hsc.usc.edu.

Reconnecting Youth (by Jerald Herting and Leona Eggert). This program is designed to help youth at high-risk for high school dropout to stay in school. The program is a class taken for credit that meets for one hour every day for a whole semester. Students with high absenteeism, low grades, or who are behind in credits are invited, not required, to participate. Classes have a 1:10 teacher: student ratio. The interventions are culturally and developmentally appropriate and are focused on counteracting prevailing norms for high school dropout by using motivational techniques. They involve skills training, self-monitoring, school bonding social activities, enhanced parent-teacher communication, and positive reinforcement. Class leaders can be teachers, health educators, or

mental health counselors. Leader training takes about 40 hours. For more information, contact Jerald Herting at herting@u.washington.edu or Nanci Bratcher at (805) 682-6667.

Other General Resources

The University of California Los Angeles' Center for Mental Health in Schools offers resources and publications online. Information is presented in a variety of formats including selected journal articles, policy reports, newsletter articles, training and presentation resources, resource packets, and center reports. <http://smhp.psych.ucla.edu>

The University of South Florida's Research and Training Center for Children's Mental Health has developed a guide for decision-makers engaged in developing and implementing SBMH services. This resource (1) describes the principal models and approaches identified in the literature from mental health and education, (2) critiques the empirical support for the approaches described, and (3) suggests how science, policy, and practice can be integrated to achieve effective school-based mental health service systems through the adoption of the public health model. <http://rtckids.fmhi.usf.edu/rtcpubs/study04/default.cfm>

The University of Maryland's Center for Mental Health Assistance provides electronic resources online. Web site content includes resource packets, system of care resources, center meeting notes, research articles, and legislative updates. <http://csmh.umaryland.edu/who>.

Other Resources

American Academy of Child and Adolescent Psychiatry (2007). Practice parameters.
[http://www.aacap.org/page.ww?section=Practice+Parameters&name=Practice Parameters](http://www.aacap.org/page.ww?section=Practice+Parameters&name=Practice+Parameters).

The AACAP Practice Parameters are designed to assist clinicians in providing high quality assessment and treatment that is consistent with the best available scientific evidence and clinical consensus. The Practice Parameters describe generally accepted practices, but are not intended to define a standard of care, nor should they be deemed inclusive of all proper methods of care or exclusive of other legitimate methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a patient and family must be made by the clinician in light of all of the clinical evidence presented by the patient and family, the diagnostic and treatment options available, and available resources. Practice Parameters for Reactive Attachment Disorder, Post Traumatic Stress Disorder, Anxiety Disorder, Depressive Disorder, Oppositional Defiant Disorder, and Conduct Disorder are available.

Bloomquist, M., and Schnell, S. (2002). Helping children with aggression and conduct problems: Best practices for intervention. New York, NY, US: Guilford Press.

Selected chapters from this book describe how to incorporate social competence trainings, parent and family skills trainings, mental health interventions, and skill building programs into the school curriculum. Challenges in implanting these interventions are also discussed.

Center for School Mental Health Assistance. (2002). Empirically-supported interventions in school mental health. Baltimore, MD: Author.

This is a resource packet which outlines the empirically-supported best practice school-based interventions. The packet also includes selected preventive interventions.

Craven, M., and Bland, R. (2006). Better Practices in Collaborative Mental Health Care: An Analysis of the Evidence Base. Canadian Journal of Psychiatry, 51 (6), 1S–72s.

Objectives: To conduct a systematic review of the experimental literature in order to identify better practices in collaborative mental health care in the primary care setting. **Methods:** A review of Canadian and international literature using Medline, PsycInfo, Embase, the Cochrane Library, and other databases yielded over 900 related reports, of which, 38 studies met the inclusion criteria. A systematic review and descriptive analysis is presented, with key conclusions and best practices.

Results: (1) Successful collaboration requires preparation, time, and supportive structures, building on preexisting clinical relationships. (2) Collaborative practice is likely to be most developed when clinicians are co-located and most effective when the location is familiar and non-stigmatizing for patients. (3) Degree of collaboration does not appear to predict clinical outcome. (4) Enhanced collaboration paired with treatment guidelines or protocols offers important benefits over either intervention alone in major depression. (5) Systematic follow-up was a powerful predictor of positive outcome in collaborative care for depression. (6) A clear relation between collaborative efforts to increase medication adherence and clinical outcomes was not evident. (7) Collaboration alone has not been shown to produce skill transfer in PCP knowledge or behaviors in the treatment of depression. Service restructuring designed to support changes in practice patterns of primary health care providers is also required. (8) Enhanced patient education was part of many studies with good outcomes. Education was generally provided by someone other than the PCP. (9) Collaborative interventions that are part of a research protocol may be difficult to sustain long-term without ongoing funding. (10) Consumer choice about treatment modality may be important in treatment engagement in collaborative care (for example, having the option to choose psychotherapy vs. medication).

Conclusions: A body of experimental literature evaluating the impact of enhanced collaboration on patient outcomes—primarily in depressive disorders—now exists. Better practices in collaborative mental health care are beginning to emerge.

Evans, S., and Weist, M. (2004). Implementing Empirically Supported Treatments in the Schools: What Are We Asking? *Clinical Child and Family Psychology Review*, 7 (4), 263–267.

The research reported in this special issue addresses important areas for the continued development of empirically supported school-based treatments. Although advances in the development and evaluation of treatment services have occurred, there is little public demand for the widespread dissemination of these treatments. In this commentary, the authors draw data from historical examples, related research, and personal experience to demonstrate the need to create a societal mandate for change. They present specific implications for future areas of research and the type of public education and marketing campaign that will be needed to create a demand for empirically supported school-based treatments.

Frey, A., and George-Nichols, N. (2003). Intervention Practices for Students with Emotional and Behavioral Disorders: Using Research to Inform School Social Work Practice. *Children and Schools*, 25 (2), 97–104.

This article examines intervention practices for children with emotional and behavioral disorders and provides recommendations for how school social workers should use the knowledge base to inform practice. Meta-analyses of intervention research for children with emotional and behavioral disorders, and the most recent literature on interventions to improve behavior, academic performance, and social skills of children with emotional and behavioral disorders are reviewed. Best practices and the unique role of school social workers in supporting best practices are presented.

Glancy, G., and Saini, M. (2005). An Evidenced-Based Review of Psychological Treatments of Anger and Aggression. *Brief Treatment and Crisis Intervention*, 5 (2), 229–248.

Therapists are increasingly treating clients with anger and aggression problems. Issues of anger control are now being addressed across various mental health settings. A wide choice of interventions, providing a range of psychoeducational treatments, is available for mental health therapists to help clients with anger and aggressive behaviors and emotions. In light of this increase in treatment, evidence-based practice to guide therapists is currently limited and poorly developed. Most past studies on anger and aggression have focused on treatments containing components of cognitive and behavioral aspects or a combination of the two. Adherents of other theoretical orientations—such as psychodynamic, psychoeducational, substance abuse counseling, and relaxation therapy—as possible effective interventions have empirically not examined their efficacies, and hence little information is known about the overall contribution of these approaches to the reduction of anger. This lack of research should not be

taken to mean that they are not efficacious, but only that they have not been adequately tested. There remains no clear consensus among therapists and researchers on the best way to treat angry clients, and little information exists to guide therapists in their work with specific angry populations. This paper introduces various treatment approaches for working with clients exhibiting angry and aggressive behaviors and provides a summary of current research findings in relation to the different psychological approaches to anger and aggression.

Hoagwood, K., and Johnson, J. (2003). School psychology: A public health framework I. From evidence-based practices to evidence-based policies. *Journal of School Psychology, 41* (1), 3–21.

This article describes current perspectives on evidence-based practices in psychology, medicine, and education. The paper also discusses challenges in the implementation and dissemination of research-based findings into schools and in particular understanding the fit between empirically validated interventions and organizational structures. Following that discussion, differences between current models of organizational behavior as studied in children's mental health services and in education are described and finally, the kinds of programmatic research models within school psychology that can move evidence-based practices towards system wide policies are described. Implications for practice and policy are noted.

Hoff, K., and Ronk, M. (2006). Implementation Guidelines: Increasing Prosocial Interactions Using Peers: Extension of Positive Peer-Reporting Methods. *Journal of Evidence-Based Practices for Schools, 7* (1), 44–46.

This article presents implementation guidelines for increasing prosocial interaction skills as well as intervention procedures using peers.

Hunter, L. (2003). School psychology: A public health framework III. Managing disruptive behavior in schools: The value of a public health and evidence-based perspective. *Journal of School Psychology, 41* (1), 39–59.

This article notes that schools typically adopt individualistic approaches to address disruptive behavior and meet the needs of students with disruptive behavior disorders (DBD; i.e., Attention Deficit Hyperactivity Disorder [ADHD], Oppositional Defiant Disorder [ODD], and Conduct Disorder [CD]). These approaches are often not the most effective and have a limited impact on overall school climate. This article emphasizes the value of an evidence-based and public health perspective in managing disruptive behavior. Information about comprehensive school-based programs and classroom management techniques for disruptive behavior disorders is presented and the important role school psychologists can play in implementing these programs discussed.

Kazdin, A., Marciano, P., and Whitley, M. (2005). The Therapeutic Alliance in Cognitive-Behavioral Treatment of Children Referred for Oppositional, Aggressive, and Antisocial Behavior. *Journal of Consulting and Clinical Psychology*, 73 (4), 726–730.

The authors examined the therapeutic alliance in evidence-based treatment for children (N=185, 47 girls, 138 boys; ages 3–14 years) referred clinically for oppositional, aggressive, and antisocial behavior. Different alliances (child-therapist, parent-therapist) were assessed from each participant's perspective at two points over the course of treatment. As predicted, both child-therapist and parent-therapist alliances related to therapeutic change, family experience of barriers to participation in treatment, and treatment acceptability. Greater alliance was associated with greater therapeutic change, fewer perceived barriers, and greater treatment acceptability. The findings could not be attributed to the influence of socioeconomic disadvantage, parent psychopathology and stress, and child dysfunction or to rater effects (common rater variance in the predictors and criteria).

Masia-Warner, C., Nangle, D., and Hansen, D. (2006). Bringing Evidence-Based Child Mental Health Services to the Schools: General Issues and Specific Populations. *Education and Treatment of Children*, 29 (2), 165–172.

In this special issue, leaders in the field discuss general issues in the transporting of evidence-based programs to children and the status of some of the more promising programs targeting specific populations. The special issue also provides in-depth coverage of SMH programs targeting specific populations. Populations covered represent the full spectrum of developmental levels and syndrome types. Two papers address the treatment of anxiety disorders. Externalizing syndromes are also covered. Despite the promise of early intervention in the prevention of conduct problems, there is little empirical data to justify or guide such efforts. The issue closes with a paper focusing on students experiencing a wide range of difficulties who are classified in educational settings as having an emotional disturbance (ED), one of the 12 disability categories defined in the Individuals with Disabilities Education Act (IDEA).

Massat, C., Ornstein, E., and Moses, H. (2006). School Social Work in the Twenty-First Century: Current Trends and Challenges in Best Practice with Mental Health Issues. *School Social Work Journal*, 31, 94–115.

This article describes trends and challenges that affect school social work best practice with mental health concerns that are commonly presented in schools. The authors describe evolving needs of students, evolving models of service, and a new emphasis on stigma reduction. The article also discusses the increased emphasis on measurement, the use of the Diagnostic and Statistical Manual (DSM-IV-TR) in schools, and the evidence base for mental health interventions. Specific disorders addressed are attention deficit hyperactivity disorder, conduct disorders, mood disorders, and anxiety disorders.

Merrell, K. (2001). Assessment of children's social skills: Recent developments, best practices, and new directions. *Exceptionality*, 9 (1), 3–18.

This article provides an overview of some of the recent developments in assessing social skills of children and youth, as well as a discussion of best practices in conducting assessment and linking assessment to effective intervention. Naturalistic behavioral observation and behavior rating scales are proposed as the two assessment methods that should be considered primary or first-line choices for social skills assessment. A review of some specific tools that have been developed within these two assessment methods is provided. Interviewing and sociometric techniques, although not necessarily primary methods of assessment for children's social skills, sometimes may be an important part of an assessment design, or second-line choices. Projective-expressive techniques or objective self-report instruments for assessing children's social skills sometimes may help illuminate the overall assessment results but should never be used as primary assessment methods for social skills; thus, these methods are considered third-line methods for this purpose. Six best-practices recommendations, all of which are supported by previous empirical research, are offered for improving social skills assessment efforts.

Merrell, K., Buchanan, R., and Tran, O. (2006). Relational aggression in children and adolescents: A review with implications for school settings. *Psychology in the Schools*, 43 (3), 345–360.

This article provides an overview of the literature on relational aggression of school-aged children and adolescents, with the specific aim of making this information relevant to school settings and education professionals. Relational aggression is discussed in terms of definitions, terms, and the importance of the school context. The literature on gender and familial influences as they relate to relational aggression is overviewed. Assessment methods for detecting relational aggression in children and adolescents are described, with an emphasis on measurement techniques most viable for capturing this sometimes-elusive construct. We conclude with a discussion of proposed best practices in school settings for effectively preventing and responding to incidents of relational aggression within the context of social and emotional learning interventions, and positive behavioral interventions and supports.

Schaeffer, C., Bruns, E., Weist, M., Stephan, S., Goldstein, J., and Simpson, Y. (2005). Overcoming Challenges to Using Evidence-Based Interventions in Schools. *Journal of Youth and Adolescence*, 34 (1), 15–22.

The Center for School Mental Health Assistance at the University of Maryland recently completed a review of evidence-based prevention and treatment programs that can be used by school mental health clinicians. Based on the review, a school-based program operating in 22 Baltimore City schools has purchased and trained clinicians in a number of protocols for evidence-based interventions. The authors present findings from this review and make pragmatic

recommendations for school mental health programs to overcome the challenges associated with the use of evidence-based interventions.

Thomas, C. (2006). Evidence-based practice for conduct disorder symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 45 (1), 109–114.

This article outlines the assessment and treatment of "Evan," a composite case based on several patients, to illustrate the application and utility of evidence-based practice (EBP) with antisocial behaviors. Evan is described as a 10 year old male referred for evaluation of bullying. The EBP procedure involved searches of the Entrez Web and PubMed Central Web sites for conduct disorder entries, and the Cochrane Database of Systematic Reviews for family and parenting treatment approaches, including wilderness programs as suggested by Evan's parents. The latter was not recommended, and using meta-analytic articles as a guide, other potential treatments were evaluated, including multi-systemic therapy, parent management training, and cognitive problem solving skills training. The latter two options are reviewed and recommended. It is concluded that application of these EBP techniques for children with symptoms of conduct disorder, however imperfectly done, is likely to be an improvement over treatment based solely on a practitioner's personal preferences.

School Mental Health Policy Resources

Center for Mental Health in Schools. (2006). Current Status of Mental Health in School: A Policy and Practice Analysis. Los Angeles: Author.
<http://smhp.psych.ucla.edu/currentstatusmh.htm>.

Responses received from the Policy Leadership Cadre for Mental Health in Schools indicated that the Center should help provide a context for the findings of the recently released SAMHSA report: *School Mental Health Services in the United States, 2002–2003*. This resource includes a policy and program analysis of the status of Mental Health in the schools.

Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., and Teich, J. (2005). School Mental Health Services in the United States, 2002–2003. DHHS Pub. No. (SMA) 05-4068. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
<http://www.mentalhealth.samhsa.gov/media/ken/pdf/SMA05-4068/SMA05-4068.pdf>.

Recent research points to public schools as the major providers of mental health services for school-aged children. The current study, *School Mental Health Services in the United States, 2002–2003*, provides the first national survey of mental health services in a representative sample of the approximately 83,000 public elementary, middle, and high schools and their associated school districts in the United States.

The purpose of the study was to identify—

- The mental health problems most frequently encountered in the United States public school setting and the mental health services delivered.
- The administrative arrangements for the delivery and coordination of mental health services in schools.
- The types and qualifications of staff providing mental health services in schools.
- Issues related to funding, budgeting and resource allocation, and use of data regarding mental health services.

The findings of the study provide new information about the role of schools in providing mental health services, and how these services are organized, staffed, funded, and coordinated.

Kutash, K., Duchnowski, A.J. and Lynn, N. (2006). School-Based Mental Health: An Empirical Guide for Decision-Makers.

<http://rtckids.fmhi.usf.edu/rtcpubs/study04/index.htm>.

The University of South Florida's Research and Training Center for Children's Mental Health has developed a guide for decision-makers engaged in developing and implementing SBMH services. This resource (1) describes the principal models and approaches identified in the literature from mental health and education, (2) critiques the empirical support for the approaches described, and (3) suggests how science, policy, and practice can be integrated to achieve effective school-based mental health service systems through the adoption of the public health model. <http://rtckids.fmhi.usf.edu/rtcpubs/study04/default.cfm>.

Center for Mental Health in Schools at UCLA. (2005). *Another Initiative? Where Does it Fit? A Unifying Framework and an Integrated Infrastructure for Schools to Address Barriers to Learning and Promote Healthy Development*. Los Angeles, CA: Author. <http://smhp.psych.ucla.edu/pdfdocs/infrastructure/anotherinitiative-exec.pdf>.

This report was developed to delineate a unifying intervention framework and an integrated infrastructure for the many initiatives, projects, programs, and services schools pursue in addressing barriers to learning and promoting healthy development. As aids for moving forward, several tools are included.

The unifying concept of an *Enabling or Learning Supports Component* is presented as an umbrella under which the many fragmented initiatives, projects, programs, and services can be pulled together. That is, such a Component can house all efforts to prevent and minimize the impact of the many problems interfering with learning and teaching and can do so in ways that maximize engagement in productive learning and positive development. For the school and community as a whole, the intent is to produce a safe, healthy, nurturing environment characterized by respect for differences, trust, caring, and support.